MSc in Public Health

Adrienne Hand

Student Reference Number: 0509810

Dissertation

Contraception and Sexual Health: What existing knowledge do 16 – 19 year old young women have and how does this compare with their practice? A Survey.

January 2007

Abstract

CONTEXT: Rates of Sexually Transmitted Infections are rising and action is still required to reduce unintended teenage pregnancies. This research establishes what knowledge and opinions young women have about preventing pregnancy and Sexually Transmitted Infections (STI's), and determines if they put this knowledge into practice.

METHODS: Utilising survey methodology a sample of 16-19 year old young women attending a local Further Education College were invited to complete a confidential questionnaire.

RESULTS: Of the young women, 79% were already sexually active with 50% of them becoming sexually active under the age of 16. The majority, 55%, reported knowing 'only a little' about Sexually Transmitted Infections, and although 100% had heard of Chlamydia, only 75% knew that it caused infertility in women and 52% assumed that it was only women that could become infected. Knowledge was slightly better regarding pregnancy, however 28% did not know that sperm can come out of a mans penis prior to ejaculation. All knew about emergency contraception, however only 65% knew that they have as long as 72 hours to access it. 62% of the young women reported having had sex without a condom in the past and only 50% knew that the condom was effective at preventing Sexually Transmitted Infections.

CONCLUSION: Although young women are of the opinion that they wish to prevent pregnancy and protect themselves from Sexually Transmitted Infections, the group surveyed do not have the knowledge that allows them to practice 'safe sex' and thus protect their reproductive and sexual health.

Acknowledgements

Thanks are extended to the numerous colleagues that have given their continued support and guidance during the development and implementation of this research.

Particular thanks go to:

Susan Sapsed, Lecturer and Dissertation Supervisor, University of Bedfordshire
Ron Driver, Statistician and Research Fellow, University of Bedfordshire
Carole Dehghani, Assistant Director of Public Health, Northamptonshire PCT
Carol Williams, Public Health Analyst, Northamptonshire PCT
Julie Luvaglio, Sexual Health Outreach Worker, Time2Talk & Northamptonshire PCT
Tessa Parkinson, Sex and Relationships Advisor, Northamptonshire County Council
Jackie Hearty – Extended Services, Northamptonshire County Council
The Staff and Students at local Further Education Colleges
Keith Hand – Editor and Husband

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1.0 Title

Contraception and Sexual Health: What existing knowledge do 16 – 19 year old young women have and how does this compare with their practice? A Survey.

2.0 Introduction

The UK has the highest teenage birth and abortion rates in Western Europe with teenage births five times more than those in Switzerland, four times more than those in the Netherlands and three times more than those in Finland (Family Planning Association, 2005). Alongside this, the UK has seen an increasing prevalence of sexually transmitted infections (STI's) and HIV (Department of Health, 2001a).

Following the publication of the report from the Social Exclusion Unit (1999) a ten-year strategy and action plan was established to halve the under 18 conception rate by 2010 (from 46.6 per 1,000 in 1998) and bring about a decline in the rate of conceptions to under 16's. Although we are moving in the right direction, the under 18-conception rate fell in 2003 to 42.1 per 1,000 and the under 16 conception rate has fallen from 8.9 per 1,000 in 1998 to 8.0 per 1,000 in 2003, much work still needs to be undertaken to reach the 2010 target of 23.3 per 1,000 in the under 18 conception rate (Family Planning Association, 2005).

The recently published Annual Report from The Independent Advisory Group on Teenage Pregnancy (2006) confirms that there is an overall decline of 11.1% in under-18 conception rates and a fall of 15.2% in the under-16 rate since the 1998 baseline. In fact, England's teenage pregnancy rate is lower than it has been for 20 years. Even though it is recognised that steady progress has been made, there is clear direction from central Government stating that this impetus must not be lost. "Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies" (Department for Education and Skills, 2006a) and the "Teenage Pregnancy: Accelerating the Strategy to 2010" (Department for Education and Skills, 2006b) both identify the factors that increase the risk of early pregnancy, the characteristics of young women who become pregnant early and the action that is required to reduce teenage pregnancy rates.

"Tackling Health Inequalities" (Department of Health, 2003) also focuses on the need to address the rates of teenage pregnancies alongside supporting teenage mothers through targeted interventions. The fact that babies born to teenage mothers are likely to have a worse start in life was recognised as far back as 1998 in the "Black Report" (Acheson, 1998) and is still strongly referenced in recent documents, for example, the recently published report on "Teenage Pregnancy, Accelerating the strategy to 2010" published by the Department for Education and Skills (2006b).

The Government Statistical Service (2004) reports that there was a 2.1% rise in the number of legal abortions performed between 2003 and 2004. 181,600 legal abortions were performed in 2003 and of the 185,415 legal abortions performed during 2004 just over 20% (38,108) were for 15 –19 year olds. In fact, the abortion rate in 2004 was highest, at 31.9 per 1,000, for women in the 18-19 year old age range. During 2002, 2003 and 2004, 32% of the women having a legal abortion had already had one or more previous abortions. Recently published figures, (Government Statistical Service, 2006), inform us that the total number of legal abortions performed during 2005 was 186,400, a rise of 0.4% since the previous year. The abortion rate was highest, at 32.0 per 1,000, for women in the 20-24 age group. There was no change from 2004 in the under-16 abortion rate at 3.7 per 1000 or the under -18 abortion rate at 17.8 per 1,000.

The sexual health of young people in the UK is poor too. Between 1991 and 2001, the number of episodes of Sexually Transmitted Infections seen in Genitourinary Medicine (GUM) clinics doubled from 669,291 to 1,332,910. Young people, in particular females under the age of 20, bear the burden of sexually transmitted infections. It is likely that an increase in risky sexual behaviour has contributed to negative sexuab health outcomes such as Sexually Transmitted Infections and unintentional pregnancy (National Statistics Online, 2004).

In "Mapping the Issues" (Health Protection Agency, 2005a:91-95) it is strongly emphasised that young people are a particular group that require targeted interventions. The report highlights that:

- Sexually Transmitted Infection rates continue to rise amongst 16-24 year olds
- Young women (74%) and men (56%) accounted for all Chlamydia diagnoses

- Young women (70%) and men (41%) accounted for all gonorrhoea diagnoses
- Young people account for 10% of HIV diagnosis each year, with the uptake of voluntary confidential HIV testing highest amongst those under the age of 25

As a consequence of poor sexual health and the long lasting impact on people's lives of unintended pregnancies and Sexually Transmitted Infections, "The National Strategy for Sexual Health and HIV" (Department of Health,2001a), the first strategy of its kind, aims to reduce the transmission of HIV and STI's, reduce the prevalence of undiagnosed HIV and STI's, reduce unintended pregnancy rates and reduce the stigma associated with HIV and STI's. With particular reference to this research, the strategy aims to ensure that clear information is available to support people so they might make informed choices regarding Sexually Transmitted Infection prevention and unintended pregnancies. It also seeks to evaluate the benefits of integrated sexual health services that have a particular focus on young people whilst meeting their sexual health needs.

Complimenting the "National Strategy for Sexual Health and HIV" (Department of Health, 2001a), one of the key commitments in the "Choosing Health White Paper" (Department of Health, 2004:145) is to tackle the prevalence of Chlamydia through the accelerated implementation of a targeted and opportunistic screening programme. The aim of this programme is to annually screen 50% of the sexually active population aged 15-24 for Chlamydia. Within the Daventry and South Northants locality of the Northamptonshire Primary Care Trust it is estimated that there are 4,155 sexually active males between 15 – 24 years and 3,597 sexually active females between 15 – 24 years, thus the screening of 3,876 people is required annually. Detailed in the "National Chlamydia Screening Programme Guidance", Primary Care Trusts are being challenged to develop innovative practices with key organisations to co-ordinate screening activities, communicate with patients and their partners, and liaise with NHS staff and the public (Department of Health, 2005:107/7)

With the above in mind, of key importance to Public Health Practitioners is promoting and protecting the populations health and well being through health promotion, prevention and screening. This research links closely to this area and as the Health

Protection Agency (2005b:7) reported, "communicable diseases, including Sexually Transmitted Infections, with particular emphasis on Chlamydia, continue to be a substantial public health issue as England is currently witnessing a rapid decline in its sexual health". Alongside this it is important to recognise that inequalities exist in relation to sexual ill health. The highest rates of Sexually Transmitted Infections are borne by women, gay men, teenagers, young adults and black and minority ethnic groups. There is also a correlation between social deprivation, sexually transmitted infections, abortions and teenage conceptions with unintended pregnancies increasing the risk of poor health and social and economic prospects for both the mother and child (Department of Health, 2001a:9).

In recent years the Government has detailed its vision for children's services through "Every Child Matters" (Department of Education and Skills, 2004) and "The Children Act" (HM Government, 2004). By reshaping children's services, to help achieve 5 key outcomes for children and young people, every child should be able to achieve their full potential regardless of their background or circumstances as they move into adulthood.

The five key outcomes for children and young people, as defined in "Every Child Matters" (Department of Education and Skills, 2004), are to:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

As detailed, "Every Child Matters" strives for all children and young people to, amongst other things, 'Be Healthy' and 'Stay Safe', in relation to this research, that is, sexually, mentally and emotionally healthy and safe from sexual exploitation.

Within educational settings much work has been undertaken to address and support the 5 outcomes for children and young people. The National Healthy School Standard (2005) has been introduced into 162 (50%) of schools within

Northamptonshire and work continues to engage the remaining 163 (50%) of schools. Utilising the whole school approach, schools are asked to demonstrate that they deliver a planned programme of Personal, Social and Health Education (PSHE) that includes Sex and Relationship Education. The National Standard ensures that the quality of teaching and learning is considered and that programmes of study are monitored and evaluated for impact, in line with DfES and Qualifications and Curriculum Authority (QCA) guidance.

School Based Health Services have been established in a number of Secondary Schools within the County. The Daventry & South Northants Primary Care Trust (2004) Public Health Annual Report highlights the essential role that these services play. At the time of publication, three secondary school services operated across the locality, this has now increased to four, of all the reasons reported for attendance, 76% of visits were related to sexual health issues. Issues ranged from advice and information through to access to condoms, other forms of contraception, pregnancy testing and emergency contraception.

Complimenting the above work in educational settings, the local young persons health service has a GP and Family Planning trained nurse to support young people with sexual health advice, support and access to contraception.

The "Alcohol Harm Reduction Strategy for England" (Prime Ministers Strategy Unit, 2004) recognises the need for young people to have clear and accessible information about alcohol to enable them to make responsible choices regarding their drinking behaviour. It is reported that young people are drinking twice as much as they did ten years ago, leading to a number of issues surrounding alcohol misuse by young people, for example, alcohol related crime, school exclusion and unsafe sex.

In a recently updated fact sheet, produced by Alcohol Concern (2006), it was highlighted that an increased number of people are drinking above the recommended limits, significantly, within certain groups of the population. 21% of men and 10% of women had drunk more than double the daily limit in one session (binge drinking) at least once in the last week. Worryingly, within the 16 to 24 year old age range, this rose to 37% of men and 27% of women. It is well documented that alcohol is a

contributory factor in risk taking behaviour, potentially resulting in unprotected sex, which can then lead to the contraction of sexually transmitted infections and unintentional pregnancy. These findings are substantiated within the "Health Survey for England" (National Centre for Social Research, 2004) which informs the reader that the greatest changes in drinking behaviour over the years have been found amongst those aged 16-24. In relation to young women, the proportion consuming 1-7 units per week decreased from 41% to 29% while the proportion consuming over 21 units per week increased from 9% in 1993 to 23%.

"Choosing Health" also responds to the alcohol agenda and recognises that the alcohol industry has a responsibility in relation to tackling the problems associated with young people drinking and binge drinking. This is supported by regulations brought in by Ofcom on the 1st January 2005, which are referenced in Choosing Health, these regulations require that

> "advertisements for alcoholic drinks on television must not appeal strongly to people under the age of 18 and advertisements must not link alcohol with sexual activity or success or imply that alcohol can enhance attractiveness."
>
> (Department of Health, 2004:37)

It is particularly important that this research has been conducted at this time, as there still remains a clear problem, both nationally and locally, with Teenage Pregnancy rates and Sexually Transmitted Infections. Although the overall under 18 conception rate in Northamptonshire has fallen against the original target, within the Daventry area the under 18 conception rate has in fact increased since the baseline year.

3.0 Aim

To establish what existing knowledge 16 - 19 year old young women have about contraception and sexual health.

3.1 Objectives

- To determine what choices young women then make about their own contraceptive usage and sexual health.

- To consider how these choices relate to knowledge and what influences them to make their decisions.

- To explore the knowledge, attitudes and behaviours of both sexually active and non-sexually active young women in relation to:
    - What young women know about Sexually Transmitted Infections, particularly Chlamydia?
    - What young women know about getting pregnant?
    - What young women know about contraception?
    - What contraception, if any, sexually active young women use?
    - What leads a sexually active young woman to make a decision about the type of contraception to use?
    - What sexually active young women are protecting themselves from, is it unintentional pregnancy and/or STI's?
    - What, if anything, influences their contraceptive usage?
    - How, and do, sexually active young women access advice and support regarding contraception and sexual health?

- To make recommendations to those organisations that provide sexual health services to young people.

This research project has been developed in such a way that it is possible for others, either across a larger geographical area or with access to different groups of young women, to implement the research and ascertain baseline and comparative information relevant to their locality and/or target group.

4.0 Literature Methodology

In order to fully define the scope of the research a literature review was undertaken. As defined by Hewitt (1998:27), this provides a concise summary of the work on the specified subject. Hart (1998:13) further supports this definition and encourages the researcher to present information on the selection of available documents which contain information, ideas, data and evaluation that is relevant to the research.

Information on previous and current works on the topics of sexual health and contraception, with particular reference to young people, were located using hard copy and electronic databases, such as, the National Electronic Library for Health, the Cochrane Library, Medline, Dialogue Data Star and Proquest. These electronic tools enabled appropriate items within the field to be searched, identified and retrieved. Journals covering and including articles on contraception, sexual health and young people were also identified, as were journals that provided abstracts of articles relevant to the search strategy. Other materials, such as reports, leaflets and conference papers were identified using other sources available, for example, the university library, the Primary Care Trust library and discussions with colleagues.

The challenge was to determine which records and pieces of information were relevant and would contribute to the research. Keywords, used individually and in combination as a means of refining searches were; Chlamydia, Sexually Transmitted Infections, Sex & Relationship Education (SRE), Personal, Social and Health Education (PSHE), 16-19 year olds, young people, Alcohol, Teenage Pregnancy, Abortion, Contraception, Condoms, Sexual Health and risk taking behaviour.

The literature review is presented thematically and covers the following topics:

- Education, SRE and PSHE
- Knowledge and attitudes regarding sexual activity, contraception and sexual health
- Sexual activity and contraceptive usage
- Risk taking behaviour linked to alcohol use
- Sexual health service usage
- Planned teenage pregnancy

5.0 Literature Review

Clearly it is essential to establish the range of national polices and strategies that relate to young people, sexual health and contraceptive usage. The findings from this area of the search strategy have been presented within the introduction and they clearly set out the context within which this research has been undertaken and demonstrate the driving forces that support the need for this research. Having established the context and rationale for the research the literature review now describes and determines what research has already been undertaken in relation to young peoples' knowledge and use of contraceptives and their sexual health behaviour and what influences it.

The Non - Statutory National Framework for Personal, Social, Health Education (PSHE) and Citizenship (QCA, 2000) states that, using a holistic approach, young people will be given an opportunity to develop their knowledge and skills and explore their attitudes in relation to:

- Developing confidence and responsibility
- Developing a healthier, safer lifestyle
- Developing good relationships

Much assumption is made about the knowledge that we feel young people have when leaving school. The Sex & Relationship Guidance states that:

> 'Sex and relationship education should prepare young people for an adult life in which they can, amongst other things, understand the reasons for having protected sex and can protect themselves from unintended/unwanted conceptions and sexually transmitted infections.' (Department of Education and Skills, 2000:20)

That said, research conducted by Magnusson (2003) amongst 589 year 9 pupils at a Hertfordshire school suggest that this is not in fact the case, many teenagers said they would like more time spent on sex education in school, they said they did not receive enough information and most of what they learned was repeated from previous years. The pupils also demonstrated limited awareness of local contraceptive services. Supporting this view further, young people involved in the "Talking about HIV" project conducted and reported by Jolly & O'Kane (2002) stated

that they did not receive enough education about HIV within school. In fact, what little information they did get focused on factual information and left no room to research social issues or discuss and challenge attitudes and values.

Knowledge regarding contraception and sexual health has been studied by a number of researchers over the years. What is clear is that basic knowledge regarding primary methods of contraception has been limited. For example, research conducted by the Health Education Authority (1999) showed that over 25% of 14-15 year olds surveyed, in a UK representative sample, thought that the contraceptive pill protected against infections. Also, when questioned in a national study, most people did not know what Chlamydia was (Dawe & Meltzer, 1999).

Cross (2000) highlights the lack of understanding and low knowledge levels when reviewing calls made to ChildLine about HIV. It is reported that one caller asked 'Can I get it from toothpaste?' and another teacher called for advice about how to answer comments from children who expressed concern about catching HIV when asked to pick up litter from the playground.

In understanding the knowledge levels that young people have about contraception and sexual health when leaving school and entering into adulthood, it is important to acknowledge the role that teachers have in delivering Sex and Relationship Education. Graham (2003) developed an intervention to be delivered by teachers in schools to increase 14-15 year olds knowledge about Emergency Contraception. It became evident that in order for teachers to effectively increase pupils' knowledge, specifically around emergency contraception, teachers themselves needed to be trained to enable them to confidently deliver accurate information.

Moving on to consider sexual activity, a recent study by Wilson (2006) from the Centre for HIV and Sexual Health reported on focus groups that incorporated the views of young men and women regarding the issues of early sex and delaying first sex. The findings of the report suggest that young men recognise the negative aspects of having early sex in relation to transmitted infections and unplanned pregnancy. Many of the young men also suggested that their first sexual

experience was not as special as they had hoped and they acknowledged that by having sex too early, and when they were not ready, could ruin their lives.

During the early part of 2006, Bliss magazine (Smosarski, 2006), surveyed 2000 girls whose average age was 14.5. Worryingly, particularly considering the mean age of the girls, 22% said they were sexually active and one in five reported that they had had sex by the time they were 14. Of those respondents that were sexually active, over 50% of them said they regretted the experience and 65% of them had had unprotected sex. For a large majority, alcohol was a major factor, with 60% admitting they were drunk when they first had sex.

Research by Chambers & Rew (2003:129-143) confirms that young women are at risk of unintended pregnancies and sexually transmitted diseases if they do not engage in safer sexual practices. Although abstinence is the safest sexual health practice for young women, once sexual activity begins, safer sexual practices involve condom and contraceptive use and communicating with sexual partners to negotiate condom use. The Stone & Ingham (2002:191-197) report suggests that despite the growing body of knowledge about teenager's sexual and contraceptive behaviour in the UK, much quantitative work has failed to consider the broader social contexts in which this behaviour occurs. In 1999 Stone surveyed 963 full-time students aged 16-18 and gathered information on individual and contextual factors to determine how they influence the use of contraception during their first sexual experience and whether such use is discussed beforehand. Results demonstrated that increased efforts should be made to develop young peoples ability to negotiate sexual and contraceptive decisions.

Furthermore Counterpoint Research (2001:9/10) conducted focus groups and in-depth discussions and found that young women found the issue of contraception problematic. Not only did they feel guilty about the frequency with which they had sex without contraception, they also found most contraception distasteful. Few discussed contraception with their sexual partners, however, few felt confident enough to take responsibility for, and control of, their contraception. One of the key findings was that many young women did not plan to have sex, and therefore didn't plan contraception. Alcohol and drugs were often involved and the context leading

up to sex was often one of 'getting out of it', that is, sex was part of escapist behaviour. Young women reported that they were concerned about STI's, however they could not use this as an argument to use contraception because its use implied they were dirty, promiscuous or both. Condoms were the second most common form of contraceptive but it was felt that they interrupted sex and partners were not trusted to use them correctly.

Much of the research links risk taking behaviour as being common in young people and that when they begin to be sexually active these risks are also associated with other health risk behaviours, such as substance misuse or alcohol intake (Tripp & Viner, 2005:590-593). The median age for first sexual intercourse in the UK dropped during the early 1990's and is now stable at around 16 years for both young men and young women. Tripp reports that about 10% of young men in the United Kingdom said that they were under the influence of drink or drugs when they first had sex and 11% of young women in the United Kingdom state being pressurised by their partner when they first had sex. As a result, the first time a young person has sex is one of the riskiest times for young people in the UK. A third of those aged 16-19 said they used no contraception the first time they had sex. Ingham et al (2000) confirms these findings in his research amongst 963 students in higher education. One quarter of sexually active 16-19 year olds had never or only rarely used condoms with their current partner. Further confirmation comes from a survey conducted by Durex (2000), in which they found that, in a representative UK sample, one in five 16-17 year olds had unprotected sex with a new partner, thereby putting themselves at risk of both pregnancy and sexually transmitted infections.

Across high schools in Rochdale, Redgrave & Limmer (2005) surveyed 2081 14-15 year olds via a qualitative questionnaire and focus groups. They found that sexual activity and problematic alcohol use were linked to young people's aspirations and getting drunk was widely accepted as normal. Basic knowledge about sexual health was lower than expected for this age group and confidence in accessing support from services was also low. Of the respondents, one-third reported having had sexual intercourse.

When the first National Survey of Sexual Attitudes and Lifestyle (Wellings et al (1994) was conducted in 1990 it revealed an increase in condom use at first intercourse among successively younger cohorts. However, when it was repeated in 2000 (Wellings et al, 2001:1843-1850) it showed that one in five sexually experienced people aged 16-24 did not use a condom at first intercourse.

The General Household Survey (2002) indicates that since 1998 there has been a significant increase in the number of women using the pill in three distinct age groups, 16-17 year olds being one of them, with 24% using the pill as opposed to 17% in 1998. This is confirmed by the Family Planning Association (2003) document Contraception: patterns of use.

Alcohol Concern (2005) suggests that studies now inextricably link the fact that young people consciously combine alcohol and sex, particularly prior to their first sexual experience and that there is also a close link to alcohol and not using contraception. Binge drinking is common, and after drinking alcohol one in seven 16-24 year olds report having had unprotected sex (Health Education Authority, 1997). This said, 16-17 year olds perceive themselves as more responsible drinkers, with an awareness of their own limits. They see their drinking behaviour as a sign of maturity. Ingham (2001) reports that in one survey of 14-20 alcohol was identified as the main reason for first sexual experiences for 20% of young men and 13% of young women.

The National Aids Trust recently commissioned MORI (2006) to undertake research into peoples knowledge and practice regarding HIV and HIV prevention. A representative sample (2,048), of the UK population, aged 15+ were interviewed face to face in their own homes across the UK. Worryingly, the survey found that awareness of how HIV is transmitted has seriously declined in the last five years. Also reported was the fact that a quarter of young people aged 15-24 stopped using condoms when they or their partner was on the pill, even though the pill offers no protection against HIV or Sexually Transmitted Infections. Furthermore, only 53% of women stated that they would always use a condom with a new partner, this is compared to only 39% of men.

The most appropriate contraceptives for young people are likely to be the condom and the pill, however teenagers have a high failure rate with both of these methods, either through non-effective condom use or irregular use of the pill. For this reason some countries are promoting the 'Double Dutch' method, using a condom and an oral contraceptive, to protect from pregnancy and STI's.

The challenge for those working with young people and shaping services is recognising that young people are being exposed to two potentially conflicting sexual health messages. One message emphasises the prevention of sexually transmitted diseases (STI's) and the other stresses pregnancy prevention. In 1997 Australian researchers Lindsay et al (1999:190-194) extracted data from 3,550 secondary school student surveys and examined teenagers' method choice and patterns of advice seeking regarding contraception and STD prevention. Logistic regression analyses were conducted to identify factors associated with the exclusive use of condoms or the pill. Findings showed that students needed to be educated about the distinction between safer sex and contraception, and about how to prevent both STD's and pregnancy.

The Health Protection Agency (2005b:23) reported that although substantial declines in the incidences of some STI's were observed throughout the 1980's and early 1990's, new diagnoses have risen continually since 1995. Around one in ten sexually active young women are infected with Chlamydia. In Northamptonshire during 2005, 28.4% (381) of new Chlamydia cases were detected in the 16-19 year old age range; this is higher than the national average for this age range, which is 26.3% (Northamptonshire Health Informatics, 2005).

Chlamydia is the most commonly diagnosed sexually transmitted infection in genitourinary medicine (GUM) clinics in the United Kingdom. As most people are asymptomatic, large proportions of cases remain undiagnosed. Untreated the infection may have serious long-term consequences, especially in women, in whom it is a well-established cause of pelvic inflammatory disease (PID), ectopic pregnancy and infertility (Department of Health, 2006b). Many young people remain unaware of the long-term implications of Chlamydia, particularly if it is left untreated.

Research by The Royal Institute of Public Health (2006) contributes the rise in Sexually Transmitted Infections to the fact that in recent years there has been a change in sexual behaviours. More people are having sex with more partners and much of this sexual activity is unprotected. In addition, poor awareness about sexual health amongst young people is also having an impact. They report that young people are increasingly unaware of the dangers of unprotected sex and the risk of HIV and Sexually Transmitted Infections is not taken seriously. Young people generally have a higher number of sexual partners, greater numbers of concurrent partners and change partners more frequently. They also hold the view that sex education in schools within the UK has failed in informing young people of the realties of being sexually active and the emphasis on teenage pregnancy has reduced the focus on sexual health.

During August 2006, BBC Radio 1 conducted the largest ever UK youth sex survey (BBC, 2006). Over 30,000 16-24 year olds completed an on-line questionnaire. Findings showed that seven out of ten young people waited until they were at least 16 to lose their virginity. However, despite the UK having the highest incidence of sexually transmitted infections in western Europe, 38% did not always use a condom with a new partner, in fact, 24% used no contraception at all the first time they had sex. Worryingly, one in ten continue to use no contraception or rely on withdrawal. Although being on the pill was the most common reason for not using a condom, 17% reported being 'too drunk' to use a condom. 43% of respondents claimed to have had at least 5 sexual partners with 18% claiming to have had 10 partners or more.

Brook (2000) undertook quantitative and qualitative research across 6 health authorities by young people attending sex advice services and they established that although 70% visited after becoming sexually active because of unprotected sex or failure of contraception, almost all those visiting the service prior to first sex went on to have safe sex. This clearly demonstrates the need to encourage young people to access sexual health services prior to having sex. Consolidating these findings Stone & Ingham, 2003:114-120) reported that of the 747 respondents completing a questionnaire, whilst attending a targeted sexual health service, 29% had used a sexual health service before ever having sex, most commonly 'to be prepared'. In

contrast, 61% of respondents had used a service after sexual intercourse. Among the women, 20-24% had been embarrassed or scared, or concerned about confidentiality or age. 32% had visited a provider because they had unprotected sex. This research highlights the need to encourage young people to be realistic about the possibility of having sex so that they are enabled to be prepared.

As demonstrated above, the majority of young people will not access a sexual health service prior to becoming sexually active, thus putting them at a higher risk of catching a sexually transmitted infection as they are more likely to have unprotected sex. It is therefore encouraging to see that recent guidance produced for those providing specialised sexually transmitted infection services within primary care (NHS, 2005:4) have highlighted the need for staff to have the appropriate knowledge, skills and attitudes to work with young people as and when they do access the service. It is essential that when a young person accesses services they are appropriately treated and the service can meet their needs.

Research conducted by Churchill (2000) further demonstrates the need for those in General Practice to acknowledge the specific requirements of young people and teenagers when accessing services. Utilising a cross sectional questionnaire survey and retrospective case-note review, 886 teenagers in the Trent region participated in research to determine whether or not their health needs were being met within General Practice. The findings of the research confirmed that whilst teenagers aged 13-15 consult their general practitioner relatively infrequently, they have expressed needs and concerns that are not being met. The lack of waiting room privacy, the presence of a doctor with an interest in teenage health and assurances of confidentiality are considered to be essential factors in improving services for young people.

When considering young peoples reproductive and sexual health it is essential to consider those young people who actively seek to become pregnant. There is now a growing body of evidence that shows 'planned' teenage pregnancies exist in the UK, however little has been done to determine and explore the reasons behind these pregnancies. Cater & Coleman (2006) conducted a qualitative study using, one to one, in-depth interviews with 41 young women and 10 young men who reported a

'planned' pregnancy. The researchers challenged the argument presented in the Teenage Pregnancy Strategy that suggests that, 'the first conscious decision that many teenagers make about their pregnancy is whether to have an abortion or to continue with the pregnancy' (Social Exclusion Unit, 1999:28). Many of the young people involved in the research clearly stated that they thought they had effectively improved their lives by becoming independent, they had escaped poor family circumstances and they had gained a sense of purpose. Rather than seeing education, training or employment as a means to change their lives, pregnancy was seen as the option that was totally within their control that could change their lives. Much of the work undertaken in the field is orientated towards the prevention of unintended pregnancies, however it must be recognised that for some young people, there is nothing unintentional about their pregnancy at all.

Interestingly, much of the literature and research cited was undertaken when the Teenage Pregnancy Strategy was first initiated and up to date research literature, specifically in relation to current contraceptive practice, is limited. This research will fill this gap, particularly at a local level, and enable service providers to determine what knowledge levels are present regarding preventing pregnancy and sexually transmitted infections amongst young women and how this knowledge is put into practice. Also a lot of the earlier research was conducted in young peoples sexual health services, therefore you would assume that the current sexual health practice of these young people would be more in line with safer sex recommendations and also their recall about sexual practice might be influenced by being in a sexual health setting. For these reasons it is appropriate to have conducted the research in an educational establishment, other than a school, that does not currently have strong associations with sexual health services.

6.0 Research Methodology

A methodology refers to the approach or paradigm that underpins research. At the outset, it is essential for researchers to consider the implications of methodological issues and the kinds of knowledge it is possible to produce (Blaxter et al, 2003: 59). In essence, the methodology is 'a system of methods and rules which facilitate the collection and analysis of data' (Hart, 1998:28). A range of methodologies exists; naturalistic, experimental and survey; each possesses particular benefits for the researcher when appropriately applied.

Choices of naturalistic methodologies are available to the researcher, for example, phenomenology, grounded theory and action research. Each of these methodologies allows for descriptive research to take place in a natural, unmanipulated, social setting, thus facilitating a less obtrusive research experience for the participant (Bowling, 2002:434). Of particular note with this form of methodology is the opportunity for the researcher to delve further and ask more questions, to continually develop a theory, to explore a social phenomena or to solve problems, particularly if utilising action research (Burden, 2005d). For the purpose of this research, the application of a naturalistic methodology would not have been appropriate. With any form of naturalistic methodology the researcher should aim to minimise the intrusion of artificial methods of data collection, that is, the world and people being studied should be undisturbed. This would not have been feasible or suitable in relation to the research topic or the target group being studied (Bryman, 2004:31).

Rees (1997:116) describes experimental methodology as having the basic goal of producing evidence of the existence of a cause and effect relationship between two variables; these are the independent variable (the cause), and the dependent variable (the effect). Such studies generally take the form of a comparison between an experimental and control group and random allocation is applied to participants to allocate them to these groups (Bowling, 2002:32). This form of methodology engenders confidence in the robustness and trustworthiness of causal findings and, as such, experiments tend to be very strong in terms of internal validity, that is, determining whether or not a causal relationship between two or more variables is sound (Bryman, 2004:34 & 540). As this research was not designed to evaluate the

effectiveness of a specific intervention or to show a cause and effect relationship, this would not have been an appropriate methodology to apply.

For the purpose of this research and in order to define knowledge and attitudes, and their relationship to practice, survey methodology was utilised. Hutton (1990:8) describes survey methodology as;

> "a method of collecting information by asking a set of pre-formulated questions in a pre-determined sequence in a structured questionnaire to a sample of individuals drawn so as to be representative of a defined population".

This approach can allow the researcher to apply a range of techniques, for example, questionnaires, semi-structured interviews and in-depth interviews. This methodology subsequently enables an analysis to take place based on a comparison of cases, as the researcher can combine answers from individuals to produce results that apply to the whole sample. Further benefits of this methodology are that the researcher can design questions so that they are unbiased and so that they can easily lend themselves to future replication (Burden, 2005a). By utilising survey methodology the research determines the characteristics of individuals and groups, and establishes patterns in young peoples knowledge and behaviour in relation to their reproductive and sexual health (Burden, 2005a & Hutton,1990:8).

Finally, consideration must be given as to whether to employ a quantitative or qualitative approach. Traditionally, health and social care research is drawn from a positivist approach, utilising the principles and methods of the natural sciences. That is, there are facts or phenomena, which can be studied and are real. Positivism is associated with quantitative research methods, the gathering of 'hard' facts that can be quantified to measure aspects of a situation and explain differences. Conversely, utilising an interpretive approach, by exploring and describing the meaning of a phenomena as experienced and perceived by the individual, a qualitative approach is adopted to find out about thoughts, feelings and meanings. This allows the researcher to understand the perspective of the research participant (Naidoo & Wills, 2005:31i-32).

This research was undertaken using a quantitative approach, allowing facts to be gathered in a logical and controlled manner and enabling an analysis to be undertaken to begin to determine trends and patterns. Although it would also have been possible to apply a qualitative approach, the research, in its early stages, would not have lent itself to this method, as the scope of questioning would have been extremely broad. The results of the quantitative research would give direction and areas for further exploration for any future qualitative work that is undertaken.

7.0 Research Methods

Described below are the research methods implemented in order to answer the research questions, also discussed are the rationale to support the choices.

7.1 Problem Statement

The rates of Sexually Transmitted Infections continue to rise, particularly with Chlamydia, amongst young women. It is clear that the long-term implications of untreated chlamydia remain relatively unknown amongst this group. Alongside this, much work remains to be done to reach the national target of reducing unintentional teenage pregnancies by 2010.

This research brings together local baseline data that can be used to influence the future development and improvement of young peoples' sexual health services. Primarily the research establishes what existing knowledge 16 - 19 year old young women have about contraception and sexual health and then explores how they put this knowledge into practice and what influences their choices.

7.2 Research Design

Survey design, utilising a confidential self-completion questionnaire, was used to generate quantitative data. As supported by Bryman (2004:133), a survey, utilising this form of questionnaire is cheaper and less time consuming than conducting structured interviews, quicker and easier for the respondent to complete and a larger quantity of results can be gathered and analysed than that for qualitative information. In addition, anonymity is easier to protect, fixed choice questions are easy to answer and analyse and this particular method is more familiar to respondents (Rees, 1997:81). Finally, it is recognised that when working with young people, regarding a topic that they might perceive as sensitive, a confidential self-completion questionnaire may allow them to feel more able to disclose personal information (Fraser et al, 2004). This point is particularly pertinent in relation to this research as a major focus was specific to young people disclosing information about their own sexual activity and sexual health.

Bryman (2004:134) does however highlight a disadvantage of this method of research design, that is, it does not allow the researcher to probe further on any answers. Recognising this limitation, as it was not within the scope of the research, an opportunity for further research is available to develop the themes that emerge from the analysis of the qualitative data. A suggestion for how this might be done is via a focus group, as focus groups provide a rich source of insight and interpretations and further information can be gathered from the participants (Polgar & Thomas, 2003:119).

7.3 Population and Sample

It is recognised that research usually involves the collection of data from a sample of a defined population rather than from the entire population of interest. It would be costly and time consuming, if not impossible, to study the whole population (Polgar & Thomas, 2003:35). By selecting a group from a much larger population, that is similar in trait, it is possible to take findings from the study group and generalise them to the larger population (Picciano, 2003).

Daventry has a population of 70,380; of this 3,308 are young people between the ages of 16 and 19. 49% of the 3,308 young people are female, thus Daventry has a female population of 1621e The age structure of Daventry is similar to that of Northamptonshire, with the main difference demonstrated in the 20 - 29 age group (Northamptonshire Observatory, 2005:3-4).

This research focuses on 16-19 year old young women for the following reasons:

- The target group will not have had access to traditional 6th form education at secondary school as the schools in the area do not have 6th forms.
- At 16, a young person is able to access free, confidential advice and support regarding contraception and sexual health without parental consent.
- Young women in the target group are deemed neither children nor adults; the research establishes how their knowledge relates to practice prior to entering their adult years.
- This age group is within the target age range for both the Teenage Pregnancy Reduction Strategy and the Chlamydia Screening Programme.

7.4 Access

Having identified the target group for the study, 16-19 year old young women, a Further Education College was approached, and permission was sought, to undertake the research at the local campus. This approach was adopted as an effective means of accessing the target group. They were all in attendance at particular times of the week, in one location. The alternatives were to either advertise locally or canvas the target group, for example, by conducting the research in the high street and asking them to complete a questionnaire.

Initial contact was made via the telephone to an identified member of staff at the College. Subsequently, a face-to-face meeting took place, giving the researcher the opportunity to discuss the aims and objectives of the research and explore the finer details of access to the students. Following this meeting the researcher sent a letter confirming the details of the study and requested that the College confirm their approval to proceed in writing (See Appendix A).

Permission to proceed was granted in writing, (See Appendix B), and the researcher followed this up by making contact with another identified member of staff who was able to facilitate access to the students. Working with this member of staff, it was agreed that it would be possible to target and distribute the questionnaire during November and December 2006 to the students registered on four courses that were typical of the educational opportunities on offer at the College. This gave access to approximately 64 young women, out of a possible 190, who attended the college within the target age range.

7.5 Inclusion and Exclusion Criteria

Ajetunmobi (2002:124) states that inclusion and exclusion criteria must be clearly defined prior to a study being undertaken in order to minimise selection bias. Participants included in this study were young women between the ages of 16 and 19 registered as attending the identified Further Education College as full time students during the academic year 2006/7. Research participants were excluded if they did not meet the inclusion criteria and if they were involved in designing and piloting the data collection tool, it was important for the researcher to identify and work with young women that would not be eligible as part of the target group.

8.0 The Data Collection Tool

Prior to developing any data collection tool it is essential that researchers establish what it is that they want to learn and whom they are going to learn this information from. Clearly, this research was focused on generating baseline information about the knowledge that 16 –19 year old young women have regarding sexual health and contraception and how they put this knowledge into practice.

At a very early stage thought was given to what information would be required and the themes that would need to be explored within the data collection tool. Reviewing other research, strategies and reports, relevant to the topic area, helped the researcher formulate a detailed questionnaire (See Appendix C). The order in which the questions were set was very. The first set of questions were equally relevant whether or not the respondent was sexually active, they did not skip backwards and forwards, therefore maintaining the respondents interest. Each section formed a module that was topic based and the questions that asked the respondent to answer in relation to their own behaviour were put towards the end so that the respondent had become more comfortable with answering. All of these points allow researchers to create more professional questionnaires that are less irritating for respondents, increase response rates and improves results (Bowling, 2002:277).

The questionnaire was developed to facilitate the exploration of the following themes:

General Information

- Access to Sex & Relationship Education at school
- Sources of Information – where do young people learn about sexual health?

Knowledge, Attitudes and Beliefs regarding

- Sexually Transmitted Infections (STI's)
- Chlamydia
- Getting Pregnant
- Contraception Choices

Actual Behaviour

- Sexual Experience(s)
- Use of Sexual Health Services

Personal Information

- Age
- Ethnic origin

Allowing for the above, and in order to collect data that could easily be gathered and analysed to answer the research question, a self-completion questionnaire was developed to capture quantitative data. Conducting face-to-face interviews or focus groups, both recognised ways of collecting data within a survey methodology (Burden, 2005a), would not have been appropriate as they would have generated qualitative data that would have been harder and more time consuming to analyse. Ajetunmobi (2002:86) confirms that the self-completion of a structured questionnaire, as opposed to the researcher completing the questionnaire by asking the respondent questions, allows less scope for observer bias, respondents feel more able to answer questions honestly and there is less chance of the researcher systematically affecting the way in which answers are recorded. This method of questionnaire design also makes it easier to protect the privacy of participants, as it is possible to administer the questionnaire confidentially (Creative Research Systems, 2005). This is of particular importance in relation to this research as young people were being asked to disclose information about their personal behaviour. Demonstrating that mechanisms were in place to maintain confidentiality and ensure that individuals would not be identifiable in the final findings was essential.

Borgatti (1996) offers the researcher key areas for consideration whilst developing a questionnaire:

- Target the vocabulary and grammar to the population being surveyed
- Avoid ambiguity, confusion and vagueness
- Avoid emotional language, prestige bias and leading questions
- Avoid double barrelled questions
- Avoid asking about future intentions

Throughout the development of the questionnaire the researcher revisited the above guidelines on a number of occasions, particularly to ensure that the language used was understandable and appropriate and that the questions would make sense to the target audience. Alongside this, consideration was given as to what types of questions to ask, that is, open format or closed format questions. Generally, open format questions seek unprompted opinions. Although these are good for soliciting subjective data each question answered needs to be read individually and there is no

automatic way of tabulating or performing statistical analysis on them. Although by utilising closed format questions there is a danger of putting ideas into respondents heads they ensure that questions are easy and quick to answer, answers can be compared across respondents and analysed easily and the study becomes easier to replicate (Borgatti, 1996). The questionnaire was developed utilising closed questions, however a number of the questions also gave the respondent the opportunity to define 'other' if their chosen answer was not presented as an available option. There was only one opportunity presented for an open answer.

A range of closed question formats were used to elicit the information from the respondents, for example,

- Dichotomous - questions offering two choices as an answer
- Multiple choice – questions offering four or more choices as an answer
- Likert scales – statements in which the respondent shows the amount of agreement / disagreement
- Semantic differential – scales inscribed between two bipolar words allowing the respondent to select the point that most represents the direction of his/her feeling Galloway (1997)

The range of question formats used was particularly important as not only did it offer the respondent a variety of question styles, thus keeping them interested and discouraging responder fatigue, but also different question formats have particular strengths, for example, Likert Scales allow researchers to effectively question respondents about attitudes (Bryman, 2004:150).

As the questionnaire developed the researcher utilised the knowledge and skills of professionals in the fields of health, education and sexual health, for example, the Curriculum Advisor for Sex and Relationship Education, a Sexual Health Outreach Worker and the Teenage Pregnancy Reduction Co-ordinator. This helped to ensure that questions were appropriately worded, the content was accurate and that all key areas were covered.

To accompany the questionnaire the researcher developed an information sheet. This emphasised that responses were confidential, participation was voluntary, opt out could happen at anytime and consent was being given by returning a completed questionnaire. It also explained who the researcher was, why the research was being carried out and what would happen to the information that was provided. Finally, it highlighted a source of support should students have any questions and/or queries regarding their own sexual health and contraception choices following the completion of the questionnaire (See Appendix D).

Bell (2005:219) recommends that qualitative research tools are piloted, particularly the self-administered questionnaire. By doing this it is possible to test the suitability of the questions and ensure there is no ambiguity in relation to the terminology, thus identifying problems before questionnaires are administered. The pilot is also important for when the real study is carried out as there will not always be researchers present to explain questions. With this in mind, the data collection tool was piloted and the questions were pre-tested with a group of young people known to the local sexual health service and attending a different Further Education College. Although similar in characteristic to the target group, the women aged 16-19 involved in the pilot would not have been eligible as members of the final sample within the full study, this approach is recommended by Bryman (2004:160) as it is important not to affect the representativeness of any subsequent sample. Following the pilot phase and after making a few minor amendments to wording, the researcher was satisfied that the survey operated and flowed well. Also highlighted, through the pilot, was the fact that the questionnaire could be completed within 10 minutes. A point of importance for the Further Education College, as it was agreed that questionnaires would be completed within Tutor time which lasts one hour and occurs only once per week.

9.0 The Data Collection Procedure

In order to distribute the data collection tool the researcher worked in partnership with a key member of staff at the local Further Education College. The following steps were taken:

- Approval to proceed was asked for, and granted, in writing, by the NHS Research Ethics Committee (See Appendix E & F) and also the NHS Research and Development Primary Care Research Alliance (See Appendix G & H).
- Approval to access the target group was asked for and agreed, in writing, by the Further Education College (See Appendix A & B).
- The researcher photocopied the questionnaires, 2 pages of A3 paper copied double sided, folded and stapled to form a booklet. The questionnaires were collated into four bundles, one for each class that had been previously identified to receive the questionnaire.
- The researcher developed a top sheet with instructions for the four lecturers who would distribute the questionnaire to their students, asking that the lecturers encouraged their students to complete and return the questionnaire (See Appendix I).
- The researcher hand delivered the questionnaires to the member of staff at the local Further Education College.
- The member of staff at the local Further Education College distributed the questionnaires to the four tutors, who asked those students that were willing to participate, to complete the questionnaires and place them back in an envelope.
- During this stage it was key that the tutors respected the students confidentiality.
- The researcher collected the completed questionnaires from the local Further Education College the following week.
- Throughout the process the researcher kept in contact with the member of staff at the local Further Education College to ensure continuity, give support and answer questions that arose. An example of such close communication came in the reassurance, from the researcher to the member of staff, that the questionnaire would take no longer than 10 minutes for students to complete, thus allowing it to be completed within tutor time as opposed to being sent home.

10.0 Ethical Considerations and Consent

It is essential that researchers consider ethical implications. This remains true for non-experimental research, such as this study, where it was likely that ethical issues would be less acute. Linked to this research, the researcher needed to gain informed consent, give a sound explanation of the purpose of the survey and respondents needed to be told what their participation would entail and be assured that they were free to refuse to answer questions or continue with their participation (Abramson, 1999:6). Bell (2005:15) also reminds the researcher that permission must be sought to conduct the research from heads of institutions and organisations, not to mention the participants themselves.

From the outset it was clear that this research study had the potential to raise a number of ethical issues. During the development and implementation stages of study consideration was given to a range of areas with the potential to cause the most anxiety. Detailed below are accounts of the measures that were put in place to address these concerns.

10.1 Research Ethics Committee Approval

It is well documented that research conducted within the NHS requires ethical approval, thus ensuring that patients and society in general are protected from unethical research and that good research is promoted (Driver, 2005b). Even though this research was not conducted within an NHS setting or with NHS patients and/or staff, the researcher took the step of contacting the administrator of the Local Research Ethics Committee by telephone and briefly discussed the aims and objectives of the study. By request, further details were sent via e-mail and subsequently approval to proceed, without referral to a Research Ethics Committee, was granted (See Appendix E). The Research Ethics Committee Co-ordinator for Leicestershire, Northamptonshire and Rutland verified this approval in writing (See Appendix F).

The Chair of the Research Ethics Committee raised one particular issue and requested that the researcher investigate further. The issue raised related to the fact that for the purpose of consent, under 18's are regarded as minors. This led to a query regarding whether or not parental consent would be

required in order that a young person could participate in the research. The researcher sought advice and information from three main sources in order to be satisfied that parental consent would not be required. Firstly, the Department of Health (2006a) produce an on-line resource entitled 'English Consent Law: Frequently Asked Questions', this document clearly states that "young people aged 16 and 17 are presumed to have the competence to give consent for themselves". Secondly, the researcher consulted with the Named Nurse for Child Protection within the Primary Care Trust and finally the researcher also took advice from the College regarding their view on the relationship that they have with parents and students. It was made very clear that young people, when given the full facts, would be able to consent for themselves and parental consent would not be required.

10.2 NHS Research Management and Governance Approval

All research undertaken by an NHS employee, regardless of whether or not the research requires Research Ethics Committee approval, must receive approval from NHS Research Management and Governance. Following the submission of; an online application (See Appendix G), the original research proposal and confirmation that the research to be undertaken was academically sound and being supervised in an appropriate manner, approval to proceed was granted by the Leicestershire, Northamptonshire and Rutland Primary Care Research Alliance (See Appendix H).

10.3 Permission to Proceed and Gatekeeper Consent

Access to research participants is more often than not mediated by gatekeepers. Gatekeepers can be concerned with the researchers motives, what the organisation can gain from the investigation or lose in terms of staff time and costs and what the potential risks to its image may be (Bryman, 2004:518). The role of the researcher is to instil confidence in the gatekeepers regarding the rationale and methodology of the research and they also help them understand the benefits of participation.

Gatekeepers relevant to the research were identified and permission to proceed was sought from each in turn. In the first instance permission to

undertake the research was sought from the Chief Executive Officer and the Acting Director of Public Health at Daventry & South Northants Primary Care Trust (See Appendix J & K). Although the researcher was not conducting this research in a work capacity she was using the credibility of her professional role when approaching the relevant parties. Permission to proceed was granted from both parties (See Appendix L & M).

As stated previously, permission to conduct the research with students at the local Further Education College was sought and granted (See Appendix A & B). Permission to work with young people who access the local young persons sexual health service, to develop and pilot the data collection tool, was also sought and granted from the Service manager (See Appendix N & O).

10.4 Parental Consent

The National Chlamydia Screening Programme (Department of Health, 2005) is challenging PCT's to screen 50% of their sexually active population aged between 15 and 24 years old. Recognising the difficulties that targeting this same age group might bring, in particular the under 16's, the researcher chose 16 as the lower age range so as not to complicate the research with issues around parental consent. In any case, as stated previously, Department of Health Guidance states that 16 year olds are able to give consent for themselves (Department of Health, 2006a).

10.5 Informed Consent

Research participants should be allowed to agree or refuse to participate in research at any stage and they should have access to comprehensive information concerning the nature and purpose of the research (Homan, 1991:69). With particular emphasis on children and young people "Guidelines for Research", produced by the National Children's Bureau (2003), strongly endorses the British Sociological Association (BSA) Statement of Ethical Practice which states that;

> 'Research should be based on freely given informed consent and there should be complete disclosure of all relevant information regarding the

research which allows children and young people to fully understand what their participation in the research entails'.

Following this stance and adhering to the "Guidelines for researchers: information sheets and consent forms" produced by (COREC, 2005), an information sheet was produced to accompany the questionnaire that was written in a language and style that could be understood by young people (See Appendix D). Burden (2005e) confirms that the return of a completed questionnaire represents consent from the participant to include their information in the research findings.

10.6 Responder Anxiety

The researcher recognised that for some young people, completing the questionnaire might raise issues and concerns about their own sexual health. For this reason, the local young persons sexual health service agreed to have their details on the questionnaire to enable young people to make contact with them for further advice, information and support (See Appendix C & D). Within the Further Education College, the Student Support Centre was also fully aware that the research was being conducted as they may have seen a rise in the number of students accessing their services following completion of the questionnaire.

11.0 Resources and Timetable

During the early stages of this research a budget plan was submitted to Bedfordshire University, this was in order to satisfy the requirements of the 'Research Proposal' as an assessable piece of academic work. Although funding was not sought to undertake the final research, by devising an initial budget plan and including it in the paper, the researcher has demonstrated an ability to formulate a budget. This is a skill that the researcher will require should further opportunities for research present themselves, where funding is available.

Appendix P shows the budget plan as devised for the research proposal. It recognises that in order to conduct the research, funding would be required at all stages, for example, research development, implementation, data analysis and the preparation and dissemination of the results. It also demonstrates that even though funding was not sought the research project could be costed to show how much it would have been. Taking advice from the Primary Care Trusts Finance Department, the researcher's budget plan takes into account her time as a Public Health Manager and the costs that would be incurred by gaining the support of colleagues from other disciplines to support the research.

The original Research Proposal also required the researcher to demonstrate the ability to formulate a project plan; this was completed in the form of a time line and can be seen in Appendix Q. This time line has since been updated by the researcher and now shows how and when the research was actually conducted, working to very tight timescales (See Appendix R).

12.0 Data Analysis Methodology

Following the advice of Bryman (2004:219) early consideration was given to how the data would be analysed. Although data analysis is a distinct stage that normally occurs later on in the research process it should be considered at the outset, as the analysis that can be carried out is influenced by both the way in which the data is collected and the amount of data that is collected.

Prior to the final production of the questionnaire the researcher sought the advice of a Statistician at Bedfordshire University. At this meeting the researcher and the statistician discussed the options for data analysis. Earlier reading from Bryman (2005:xxiv) gave the researcher the understanding that the most widely used package for quantitative data analysis is the Statistical Package for the Social Sciences (SPSS), however at this meeting it was agreed that the Microsoft Excel Package would provide the necessary functions to both collate and analyse the quantitative data for this small scale research project. The researcher preferred the use of Excel, as this was a programme that she was already familiar with and once the data had been collated it would be possible for her to generate tables and graphs to present the findings.

During the development of the questionnaire, and prior to its distribution, each answer was coded (See Appendix C). Pre-coding, that is, deductive coding, was essential as it allowed the data to be classified into meaningful and relevant categories. For example, for the variable defined as age, in question number 57, code 1 was assigned to age 16, code 2 was assigned to age 17, code 3 was assigned to age 18 and code 4 was assigned to age 19. Adhering to the basic rules for developing a coding frame for quantitative data analysis the codes were mutually exclusive, the coding formats were comprehensive and they were applied consistently (Fielding, 1993).

As questionnaires were returned the researcher completed the coding column and the data was transferred onto a pre-prepared Excel worksheet. An extract of the coding frame worksheet can be seen in Appendix S. Once all questionnaires were returned and the data input, the Excel programme was used to measure the frequency of responses, calculate percentages and generate a range of graphs.

Commonly associated with quantitative research is the analysis of two variables at a time, this is in order to uncover whether or not they are related. In essence, this involves exploring relationships between variables and seeking evidence that shows that the variation in one variable coincides with the variation in another variable. Alongside this it is usual that results be tested for statistical significance to demonstrate a researchers confidence in findings and to prove or disprove a null hypothesis thus enabling a generalisation of findings across a whole population from which a sample has been taken (Bryman, 2004:230 & 237).

The statistical test for significance for categorical data, that is, qualitative data that cannot be measured on a scale and has no numerical value, is the 'chi square' (χ^2) test. A limitation of this test, which is particularly pertinent to this research, is that it can only provide approximate results, especially when sample sizes are small. In instances where observations are <5 the 'Fisher exact test' can be applied. (Ajetunmobi, 2002:42).

At the outset the researcher anticipated being able to compare knowledge, attitudes and opinions between those young women that were sexually active and those that were not. However, when the results were analysed the researcher established that only a very small proportion of the respondents were in fact not yet sexually active. Within the parameters of this research, with such a low number of young women not being sexually active, it has not been possible for the researcher to prove statistical significance in relation to knowledge levels between both groups of young women. Another issue, further compounded by this situation, is, that for many areas of the research where statistical tests could have been applied, observed responses were in fact too small to demonstrate any statistical significance even amongst the group of sexually active young women.

The researcher took the decision to continue to proceed with presenting the findings across the range of respondents, that is, sexually active, not sexually active and all respondents. In order to prove statistical significance it would be necessary to survey more young women from the target group in the hope that a larger proportion of young women that were not yet sexually active would be included. What has been drawn from the research is a generalisation of findings for young women attending

the further education college between the ages of 16 and 19, regardless of whether or not they are sexually active, as one in three young women attending the college completed the survey.

13.0 Results and Discussion

Presented below is an analysis of the results that have been generated from completed and returned questionnaires and the subsequent discussion regarding the findings of the research. Full results can be seen in Appendix T, where they are shown for both sexually active and non-sexually active young women.

13.1 Response Rate

The sample of 64 students approached to complete the questionnaire represented almost one in three full-time female students between the ages of 16 and 19 attending the College. Of the 64 young women targeted, 58 returned a completed questionnaire (n=58). This represented a response rate of 91%. Bowling (2002:264) states that a response rate of 75% and over is considered to be good. Of the six young women that did not return a completed questionnaire, it was reported that they were either absent or declined to participate on the day. The vast majority of young women completed the questionnaire, in full, without any problems.

13.2 Age and Ethnicity of Respondents

All respondents were female and aged between 16 and 19 during November and December 2006 (See Table 1). 45% (26) of respondents were aged 16, 29% (17) and 21% (12) were aged 17 and 18 respectively and 5% (3) were aged 19. The mean age of respondents was 17 years and 7 months. It is important to note that other research involving young people often refers to the age category of '16-18'; this research paper clearly includes those who are over the age of 18, up to and including 19 year olds. Conversely, other research in the field of sexual health considers responses from those under the age of 16, which this research paper does not do.

Table 1: Age Distribution of Respondents

Age	*n*	per cent
16	26	45%
17	17	29%
18	12	21%
19	3	5%
Total	58	100%

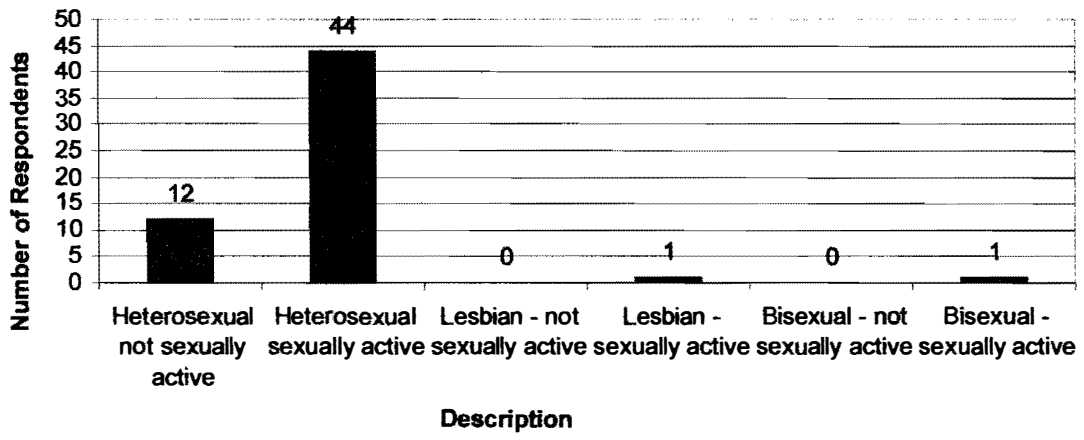
In order to analyse the data by ethnicity the researcher utilised the same categories that the Primary Care Trust uses to define ethnicity. 100% (58) of respondents reported themselves as white. This high rate is not unexpected, in the 2001 Census only 1.9% of the population of Daventry and South Northants reported themselves as belonging to an ethnic group other than 'white' (Daventry & South Northants Primary Care Trust, 2004).

13.3 Sexually Active and Non-Sexually Active Respondents

Although not covered until the latter part of the questionnaire it is important to describe the findings of this question at this stage in the paper, as many of the results are presented in relation to sexually active and non-sexually active young women.

The young women were asked to describe themselves in relation to their sexual orientation and whether or not they considered themselves to be sexually active (See Figure 1). Sexually active was defined as having taken part in a specific heterosexual activity, that is, having a penis inserted into the vagina. It was important that the researcher was able to recognise those that were sexually active heterosexuals, as exposure to Sexually Transmitted Infections and unintended teenage pregnancies are a particular focus of both the Teenage Pregnancy Reduction Strategy (1999) and the National Strategy for Sexual Health and HIV (2001). The researcher acknowledged that some young women may be questioning their sexual orientation and recognised that, had the proportion of those identifying themselves as lesbian or bisexual been higher, reported as only 2 (3%), this could have been considered as a focus for further research.

Figure 1: Self - Reported Sexual Orientation and Sexual Status (*n*=58)



Of the respondents, 75% (44) reported themselves as sexually active heterosexuals, 2% (1) as a sexually active lesbian and 2% (1) as a sexually active bisexual. Both young women describing themselves as lesbian and bisexual completed the questionnaire in relation to male partner(s) that they have had in the past, therefore the research considered that 79% (46) of respondents were sexually active and 21% (12) were not.

Rates of sexual activity were much higher than anticipated. This conclusion is drawn by comparing this research, where 79% of respondents stated they were sexually active, with research conducted by Wellings et al (2001), who reported that only 49% of 16-19 year olds were sexually active. Alongside this, research conducted by the Family Planning Association (2002) showed that by the age of 17, only 53% of their respondents had experienced sexual intercourse. Three quarters of the young women questioned in this research were aged 16 or 17, and when analysed, 72% of them were in fact sexually active.

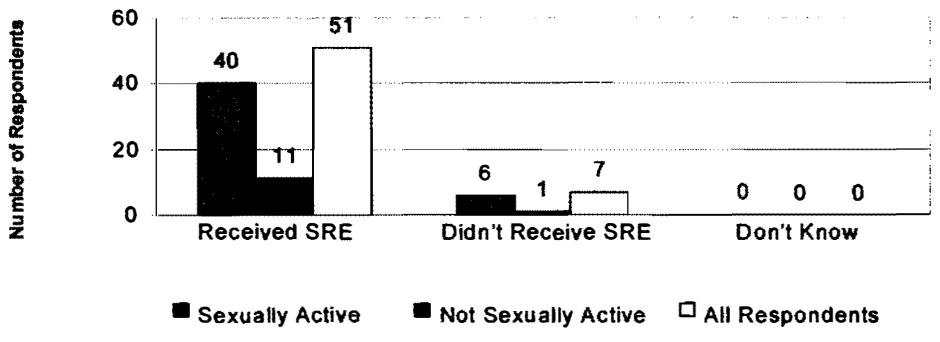
13.4 Sex & Relationship Education at School

13.4.1 Recall of Sex & Relationship Education

There is an undertaking from the Government that all young people will receive their entitlement to Sex and Relationship Education, thus preparing them for adult life. Amongst other things, they should understand the importance of having protected sex, how to prevent Sexually Transmitted Infections, and they should also know how to prevent unintended pregnancy (Department of Education and Skills, 2000). Alongside this, from professional experience, the researcher believes that it is essential that the Sex & Relationship Education that is delivered is relevant and engaging, thus enabling young people to explore their knowledge, skill and attitudes. They should also be able to recall the information at a time that is appropriate to them, for example, in preparation for becoming sexually active.

When questioned, 88% (51) of respondents recalled receiving Sex & Relationship Education at school, however 12% (7) recalled not receiving (See Figure 2). Although it may be perceived that the recall is high, taking the statement about Sex & Relationship Education being an entitlement for all into account, one would have expected a larger number of young women to remember these lessons. Sex & Relationship Education should not be a one off lesson that could be missed; it should be delivered in all schools, on a regular basis, across all year groups, building on previous learning and knowledge.

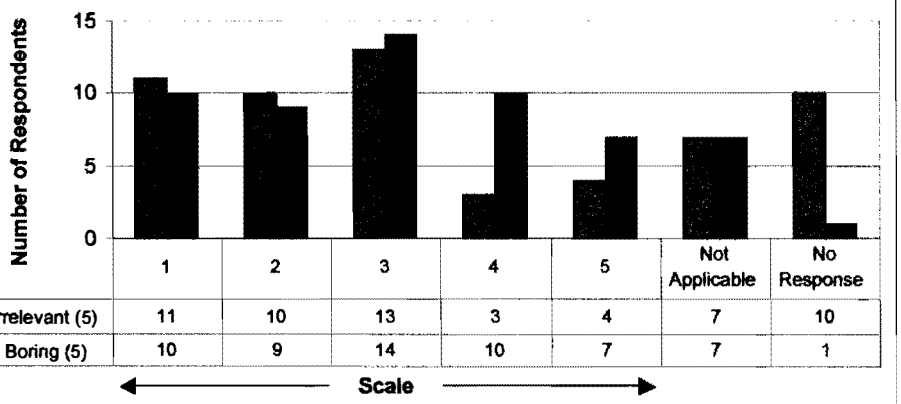
Figure 2: Sex & Relationship Education (SRE) at School - Recall



13.4.2 How was your Sex & Relationship Education at School?

Although 88% (51) of respondents recalled receiving Sex & Relationship Education at school, not all of them found it to be relevant and/or interesting (See Figure 3). The young women were asked to show, on a scale of 1 to 5, how they felt about their Sex & Relationship Education in relation to descriptive words at opposing ends of the spectrum. Of the 41 young women eligible to answer this question, only 27% (11) found their Sex & Relationship Education to be wholly relevant and only 24% (10) found it entirely interesting. More young women, 32% (13) and 34% (14), chose the middle options of neither relevant / irrelevant or neither interesting / boring respectively. These findings are similar to that of Magnusson (2003), who reported that many young people said their Sex & Relationship Education did not meet their needs. What was taught was repeated from previous years and they said that they did not receive enough information to prepare them for sexual activity.

Figure 3: Description of Sex & Relationship Education at School



13.4.3 Information about Local Sexual Health Services

The majority of young women, 76% (44), attended a school that provided information about local sexual health services. A further 14% (8) reported that their school did not provide information and 10% (6) did not know if information had been available. Knowledge about access to appropriate local services is important for young people both before and after they become sexually active. What is apparent is that almost 25% (14) of respondents may not have been made aware of, or have taken on board, the information regarding local services.

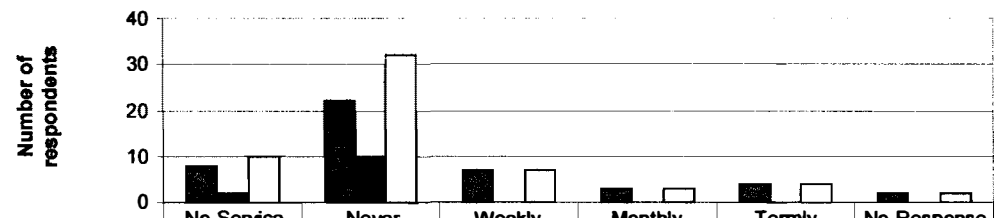
This is not to say that all young women should be accessing the services, what is important is that they have an awareness of service availability should they then wish to access them.

13.4.4 School Based Health Services

Over the past few years much work has been developed locally to provide school based health services within secondary schools. These services offer advice and support across a range of topics, including access to sexual health services. Recognising that some of the young women may have attended schools where such services have not been developed, they were asked to indicate how often they attended a school based service, where one was available, to access support and information on contraception and/or sexual health. 69% (46) of young women indicated that they had access to a school based health service, however 32 of the 46 young women reported that even when a school based health service was available, they never used it.

Only 14 respondents used the services weekly, monthly or termly (See Figure 4). None of the young women identifying themselves, as not sexually active used a school based health service. From this, it would appear that those young women that are not yet sexually active do not see the school based health service as a source of information, advice and support to prepare them for becoming sexually active. Instead the wait until they are sexually active which in many cases may be too late.

Figure 4: Usage of School Based Health Services



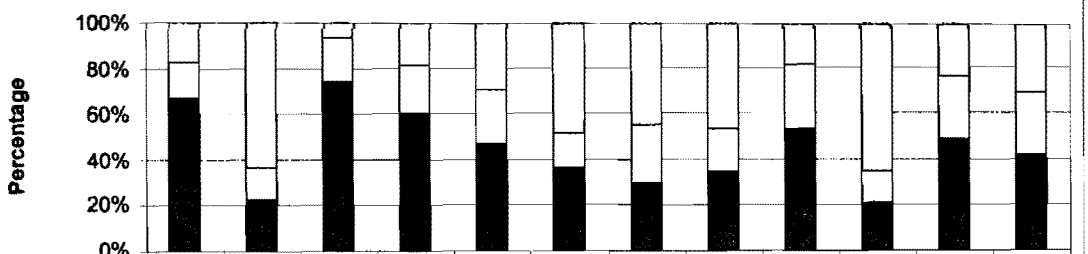
	No Service	Never	Weekly	Monthly	Termly	No Response
■Sexually Active	8	22	7	3	4	2
■Not Sexually Active	2	10	0	0	0	0
□All Respondents	10	32	7	3	4	2

13.5 Sources of Information

As can be seen in figure 5, the majority of young women, regardless of whether or not they were sexually active, gained most of their information about relationships and sexual health from their friends, 74% (43), and parents, 67% (39). The main difference between those that were sexually active and those that were not, were those that reported their boyfriends and partners as a source of information, as would be expected, this was particularly true for those that were sexually active. This draws attention to the need to ensure that young men are fully engaged in Sex & Relationship Education and are skilled to deal with the complexities surrounding contraception and sexual health.

The TV and the movies appeared to be other influential sources of information, with 53% (31) of respondents reporting that they get a lot or some information from these sources. Both sexually active and non-sexually active young women, 48% (28), also use magazines as a popular source of information, however contrary to other research, the internet was not a popular source, only 20% (12) said they get a lot or some information at all from the internet with 65% (38) stating they get no information at all from this source. Research conducted by the BBC (2006), reported that 59% of their respondents sourced information about sex on the Internet.

Figure 5: Sources of Information (*n*=58)



	Parents	Brothers / Sisters	Friends	Boyfriends / Partners	Teachers	School Health Nurses	Young Persons Service	Doctor / Practice Nurse	TV Shows / Movies	The Internet	Magazines	Leaflets
Nothing at all	10	37	4	11	17	28	26	27	11	38	14	18
Only a little	9	8	11	12	14	9	15	11	16	8	16	16
Some	22	5	24	27	21	14	8	12	20	7	18	17
A lot	17	8	19	8	6	7	9	8	11	5	10	7

Recognising that teachers are also seen as a source of information for some young people, 46% (27) reported receiving a lot or some information from teachers; it is essential that teachers feel confident and able to deliver Sex & Relationship Education across the board. This is borne out by research conducted by Wilson (2006), who found that in order for teachers to effectively increase pupils' knowledge about emergency contraception, teachers themselves needed to be trained to enable them to confidently deliver accurate information.

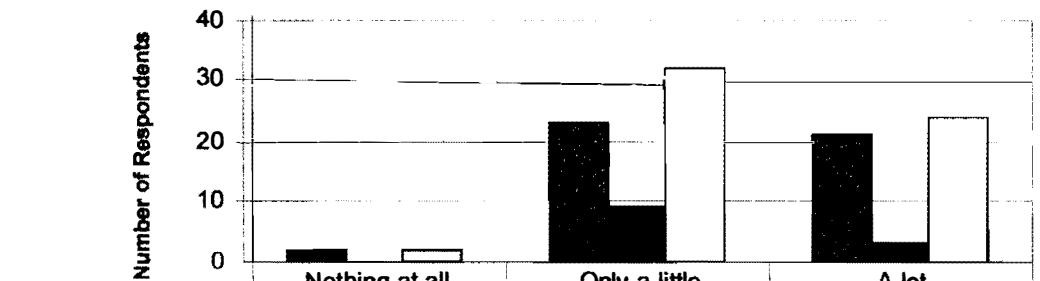
13.6 Sexually Transmitted Infections

13.6.1 What do You Know About Sexually Transmitted Infections?

The UK is witnessing rising rates of Sexually Transmitted Infections, particularly amongst young women under the age of 20 (National Statistics Online, 2004). It is therefore essential that young women, regardless of whether or not they are sexually active, have a full understanding of what Sexually Transmitted Infections are, how their spread can be prevented and what the implications are of both catching one and not seeking treatment.

From the research findings 3% (2) of respondents felt that they knew nothing at all about Sexually Transmitted Infections, of concern is that, both reported that they were already sexually active. Further analysis of their particular responses to other questions demonstrated that they have a lack of understanding about the role that condoms play in preventing Sexually Transmitted Infections and how easily Sexually Transmitted Infections can be spread. The majority of respondents, 55% (32), felt that they knew only a little about Sexually Transmitted Infections and only 42% (24) reported that they knew a lot (See Figure 6).

Figure 6: Sexually Transmitted Infections – Knowledge Levels



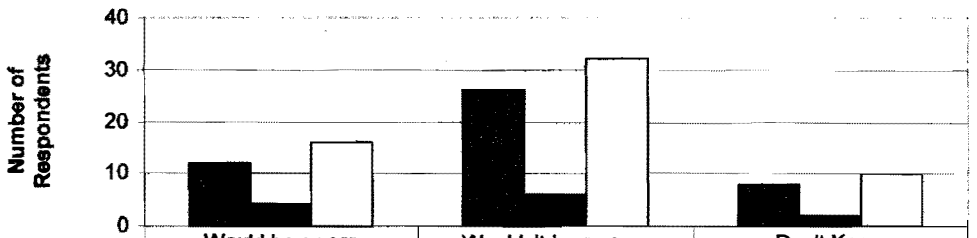
	Nothing at all	Only a little	A lot
Sexually Active	2	23	21
Not Sexually Active	0	9	3
All Respondents	2	32	24

As might have been expected, a higher percentage of young women that were not yet sexually active, 75% (9), reported knowing only a little about Sexually Transmitted Infections compared to 50% (23) of sexually active young women. Of those that reported knowing a lot about Sexually Transmitted Infections, a higher proportion, 46% (21), were sexually active compared to only 25% (3) that were not sexually active.

13.6.2 Would you know if you had a Sexually Transmitted Infection?

Respondents were asked if they would always be aware if they had a sexually transmitted infection, just over half, 55% (32), correctly stated that they would not always be aware (See Figure 7). What this indicates is that 45% (26) of those questioned either thought that they would always be aware if they had a sexually transmitted infection or they didn't know. A lack of such basic knowledge has the potential to put somebody at risk of catching or spreading a Sexually Transmitted Infection, as symptoms are not always present. Although there was very little difference between the knowledge levels of sexually active and non-sexually active young women regarding this question, proportionately the non-sexually active young women demonstrated slightly more awareness.

Figure 7: Would you be aware that you had a Sexually Transmitted Infection?

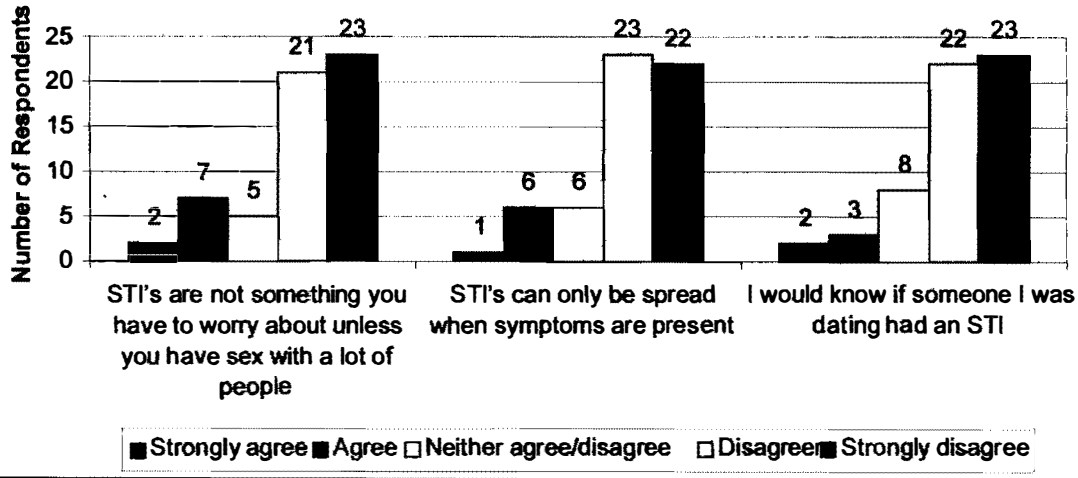


	Would be aware	Wouldn't be aware	Don't Know
Sexually Active	12	26	8
Not Sexually Active	4	6	2
All Respondents	16	32	10

13.6.3 Sexually Transmitted Infections - Opinions and Knowledge

The young women were asked to record their responses to some statements that sought their opinions and further tested their knowledge regarding Sexually Transmitted Infections (See Figure 8). In relation to Sexually Transmitted Infections and sexual partners, 76% (44) of the young women disagreed or strongly disagreed with the statement 'you only have to worry about Sexually Transmitted Infections if you have a lot of partners'. This response led the researcher to assume that these young women would make a correlation between using condoms as a means of preventing Sexually Transmitted Infections even if they did not have a lot of sexual partners. Of those 44, 33 were sexually active and 26 of them reported having had sexual intercourse without a condom, their opinions are not borne out in their practices.

Figure 8: Sexually Transmitted Infections – Opinions & Knowledge (*n*=58)



Subsequently, respondents were asked to consider whether or not Sexually Transmitted Infections could only spread when symptoms were present. The majority of young women, 78% (45) correctly disagreed or strongly disagreed with this statement that tested their knowledge, however the 22% (13) that either strongly agreed, agreed or neither agreed nor disagreed with the statement could put their own sexual health at risk as they may think that symptoms would be visible. 12 of the respondents in the latter category are already sexually active.

Finally, respondents were asked if they would be aware if someone they were dating had a Sexually Transmitted Infection. Again the majority of the young women, 78% (45), correctly disagreed or strongly disagreed with this statement. However, the remaining 22% (13) who strongly agreed, agreed or neither agreed nor disagreed, once again demonstrate a lack of knowledge. All 13 in this latter category are sexually active.

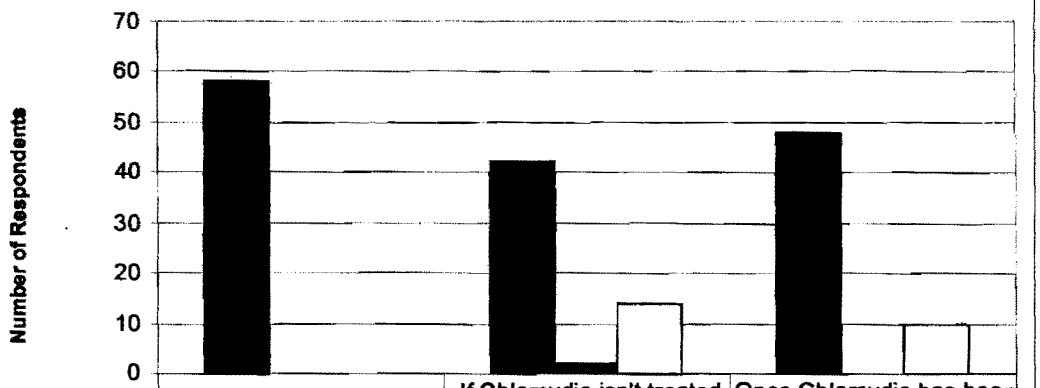
What is evident after the analysis of these three statements is that proportionately, non-sexually active young women have stronger views and their knowledge levels are higher than those of sexually active young women. For example, in response to the second statement 92% of non-sexually active young women strongly agreed or agreed with the statement, whereas only 74% of sexually active young women strongly agreed or agreed with the statement.

13.7 Chlamydia

13.7.1 Chlamydia - Knowledge

When questioned about Chlamydia (See Figure 9) all respondents reported having heard of the Sexually Transmitted Infection, however 24% (14) of the young women didn't know that it caused infertility in women and 17% (10) didn't know if you could get it again once it had been treated. The long-term consequences of this lack of knowledge, for these young women, could result in future reproductive problems should they get Chlamydia and it remain untreated. Considering that it is estimated that one in ten sexually active young women are infected with Chlamydia, and rates are higher in Northamptonshire than other parts of England, this would not be unlikely (Northamptonshire Health Informatics, 2005).

Figure 9: Chlamydia – Knowledge Levels (*n*=58)

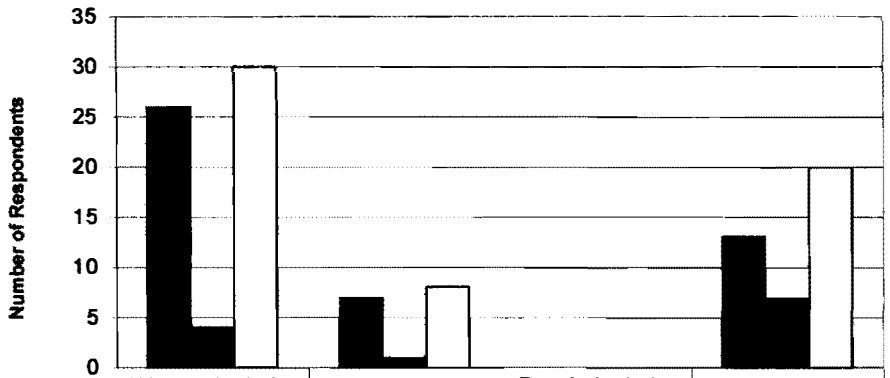


	Have you heard of the STI Chlamydia?	If Chlamydia isn't treated can it cause infertility in women?	Once Chlamydia has been treated can you get it again?
Yes	58	42	48
No	0	2	0
Don't Know	0	14	10

13.7.2 Who is most likely to get Chlamydia?

Knowledge levels regarding those most likely to get Chlamydia, the symptoms of Chlamydia and the methods for detecting Chlamydia are low. Figure 10 reveals that the majority of young women, 52% (30), assumed wrongly, that only women could become infected with Chlamydia. Only 14% (8) of respondents answered correctly, that is, people under 30 are most likely to get Chlamydia.

Figure 10: Who is most likely to get Chlamydia?

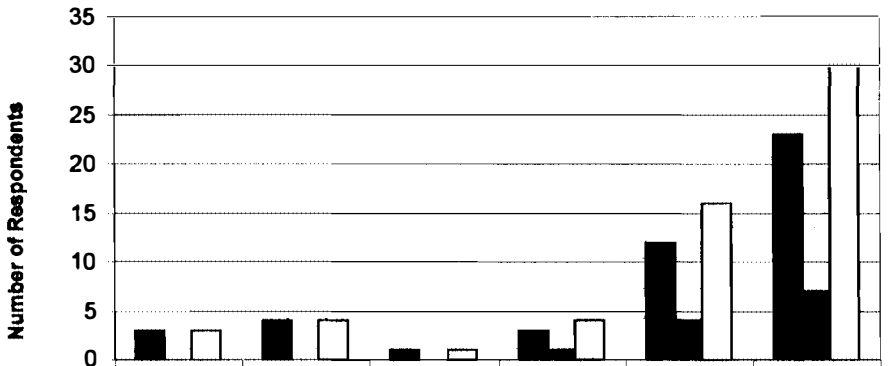


	Women in their 20's/30's	People Under 30	People in their 30's/40's	Don't Know
Sexually Active	26	7	0	13
Not Sexually Active	4	1	0	7
All Respondents	30	8	0	20

13.7.3 Symptoms and Detection of Chlamydia

Knowledge regarding the symptoms of Chlamydia was mixed (See Figure 11). An important fact that both young women and men must be aware of is that they may display no symptoms at all but still have Chlamydia. Those that answered 'None of the symptoms', only 27% (16), were correct. Over half of the young women responding, 52% (30), stated that they did not know what the symptoms were. The proportion of young women answering 'Don't Know' didn't change whether they were sexually active or not.

Figure 11: What are the symptoms of Chlamydia?



	A spreading itchy rash	Pus filled lumps	Paralysis in a limb	All of the symptoms mentioned	None of the symptoms	Don't Know
■ Sexually Active	3	4	1	3	12	23
■ Not Sexually Active	0	0	0	1	4	7
□ All Respondents	3	4	1	4	16	30

Although either a swab or a urine sample can be used to detect Chlamydia, the urine sample is the least invasive and most simple method used. As part of the Chlamydia Screening Programme, the urine sample is recognised as an effective detection method when seeking to opportunistically test large numbers of young people who may attend venues other than clinical settings (Department of Health, 2005). Only 17% (10) stated giving a urine sample as the answer as opposed to 52% (30) who stated that a swab would most commonly be used. 17% (10) didn't know what would be used to diagnose Chlamydia. Knowledge regarding the detection and treatment of Chlamydia needs to be relayed to young people so that they know what course of action will be taken if they have put themselves at risk.

13.7.4 Protection against Chlamydia

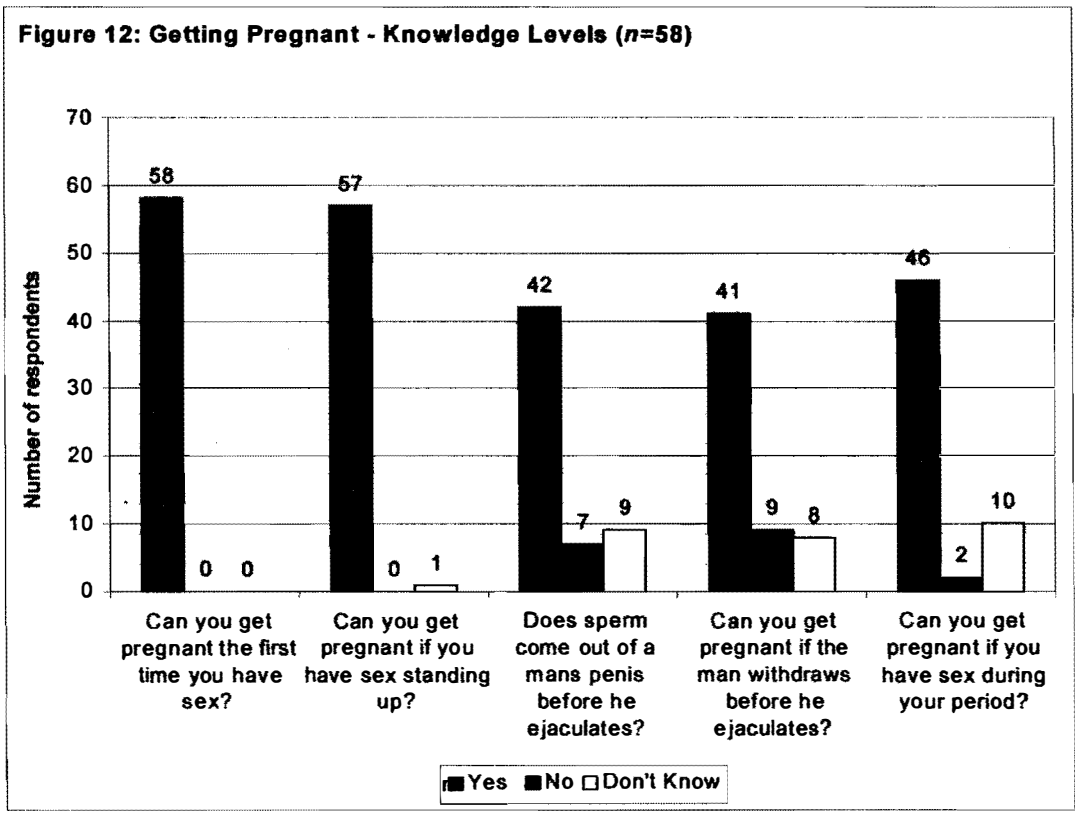
79% (46) of respondents correctly answered that the condom was the most effective method of protection against Chlamydia. However, 2% (1) wrongly stated the pill and the remaining 19% (11) did not know the answer to this question. Of the 11 who did not know the answer, 7 were already sexually active, suggesting from their answer that they do not have an awareness of how to protect themselves from Chlamydia. When analysing this data set further it appears that of these 7 young women, 5 of them used a condom the last time they had sexual intercourse and they reported that it was important that their contraception protects them from Sexually Transmitted Infections. This may suggest that they are following the recommended practice but not fully understanding why.

The findings from both this section of the research relating to Chlamydia and the previous section on Sexually Transmitted Infections in general were not unexpected. Previous research regarding knowledge of Sexually Transmitted Infections (Office for National Statistics, 2003), showed that although 90% of 16-19 year old young women were aware of the Sexually Transmitted Infection Chlamydia, 31% didn't know that it doesn't always cause symptoms and 46% didn't know that it is easily treated by antibiotics. What is surprising is that even after the emphasis that has been placed on improving school based Sex & Relationship Education over the past three years and the media coverage regarding the rising rates of Sexually Transmitted Infections, knowledge levels are varied and still appear to be low.

13.8 Getting Pregnant

It is not only important that young people are able to protect themselves from Sexually Transmitted Infections; they also need to know how to avoid unintentional pregnancy. Generally, it would appear that knowledge levels regarding getting pregnant are relatively high (See Figure 12), especially when compared with knowledge regarding Sexually Transmitted Infections. All respondents correctly stated that you could get pregnant the first time you had sexual intercourse. Only 2% (1) of respondent were not sure if you could get pregnant if you had sex standing up, this respondent was not sexually active.

Figure 12: Getting Pregnant - Knowledge Levels (*n*=58)



Knowledge levels decreased when respondents were asked about sperm coming out of a penis before ejaculation. 72% (42) of young women answered this question correctly, however 28% (16) either answered the question wrongly or didn't know the answer. Furthermore, when questioned in relation to the possibility of getting pregnant if the man withdraws before ejaculation, 71% (41) answered correctly, with the remaining 29% (17) either answering the question wrongly or not knowing the answer. Knowledge in relation to these two questions is particularly important in order that young

women may prevent themselves from becoming pregnant unintentionally. As will be seen later in this paper some young women use no form of contraception/protection and rely solely on withdrawal to avoid pregnancy.

Finally, respondents were asked if they could get pregnant if they had sexual intercourse during their period. 79% (46) of young women answered this question correctly and 21% (12) either answered wrongly or did not know the answer. In relation to the last three questions described in figure 12, proportionately, knowledge levels regarding getting pregnant were higher in sexually active young women than in non-sexually active young women.

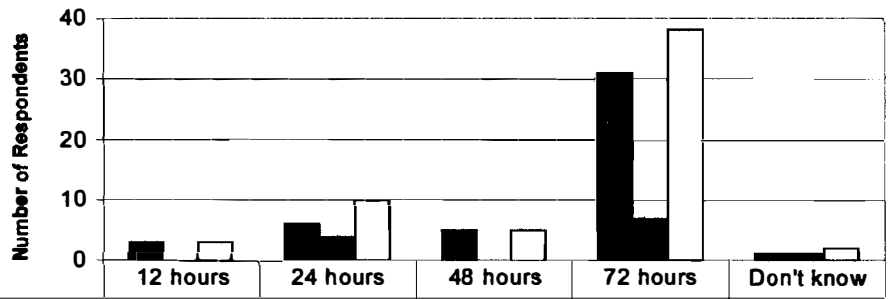
13.9 Emergency Contraception

As will be discussed later, this research shows that some of the young women have had concerns about being pregnant because of either something they did sexually whilst under the influence of alcohol or because they had unprotected sexual intercourse. With this in mind, it is essential that young women are aware of emergency contraception and the period of time in which they can access it for it to be most effective

All young women reported having heard of emergency contraception or the morning after pill, as it is frequently referred to. However, when questioned to see if there was something that could be done to prevent a pregnancy following unprotected sex or contraceptive failure the number of young women answering positively dropped to 91% (53). Of the 5% (3) and 3% (2) that answered 'No' and 'Don't Know' respectively, all were sexually active. On further analysis, only 2 of these 5 women use contraception or protection all of the time, the other 3 only use it most of the time, leaving themselves at risk of an unintentional pregnancy.

What is also clear, following an analysis of the responses, is the lack of knowledge regarding how long you might have after unprotected sex / contraception failure to use emergency contraception (See Figure 13).

Figure 13: Emergency Contraception - Knowledge Levels



	12 hours	24 hours	48 hours	72 hours	Don't know
■ Sexually Active	3	6	5	31	1
■ Not Sexually Active	0	4	0	7	1
□ Total Respondents	3	10	5	38	2

Only 65% (38) of respondents knew that they had up to 72 hours to access emergency contraception, this means that 25% (20) of the young women participating are lacking accurate information and may think that they are too late to access emergency contraception, should the need arise.

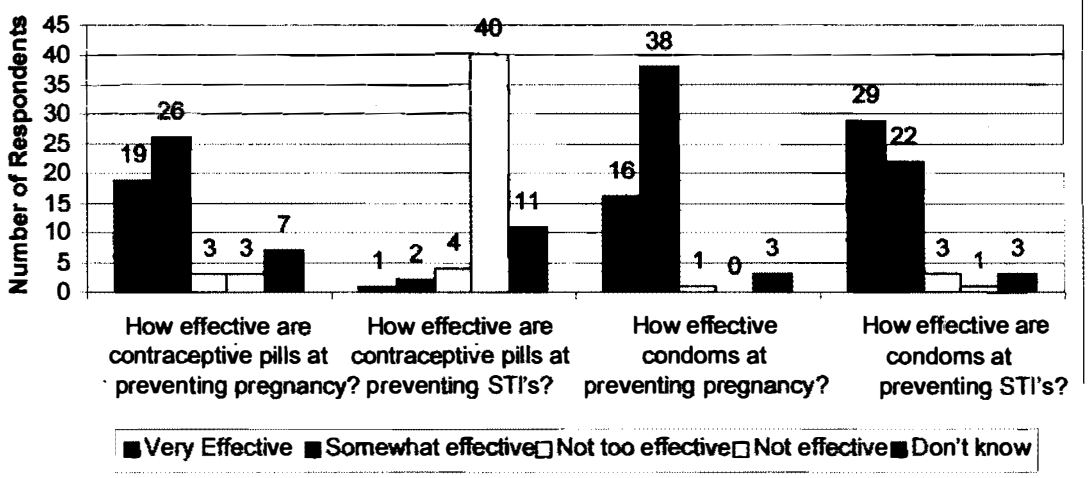
Statistics and previous research regarding knowledge levels and the use of emergency contraception are lacking, therefore it is not feasible for the researcher to comment regarding the findings of this part of the questionnaire in relation to other research. What is clear, however, is the need to ensure that young women are made aware of the 72-hour time frame and effort should be put in to challenge the use of the phrase 'the morning after pill', as this is often interpreted literally in relation to the time frame available within which to use emergency contraception.

13.10 Relationships and Contraceptive Choices

13.10.1 Contraceptive Choices - Effectiveness

Respondents were asked to consider how effective they felt oral contraceptive pills and condoms were in relation to preventing both pregnancy and Sexually Transmitted Infections (See Figure 14). The contraceptive pill, if used correctly, is known to be 99% effective in preventing pregnancy and the condom, again if used correctly, is known to be 98% effective in preventing pregnancy, it is also the most effective method to protect oneself from Sexually Transmitted Infections beyond abstinence (Schering, 2003).

Figure 14: Types of Contraception & Protectione- Knowledge Levels (*n*=58)



Only 40% (19) felt that the oral contraceptive pill was very effective at preventing pregnancy, more, 49% (26), responded that it was somewhat effective. 22% (13) either didn't think it was effective or didn't know. When asked how effective the contraceptive pill was at preventing Sexually Transmitted Infections, 31% (18) of young women either answered wrongly or didn't know the answer, only 69% (40) of young women knew that the contraceptive pill is not effective at preventing Sexually Transmitted Infections.

In relation to condoms and their ability to prevent pregnancy, only 27% (16) thought they were very effective whilst the majority, 66% (38), thought they were somewhat effective. 7% (4) either didn't know or thought they were not too effective. When asked about condoms and their capacity to prevent

Sexually Transmitted Infections only 50% (29) correctly stated that they were very effective, with 38% (22) feeling that they were somewhat effective. 12% (7) of young women either thought they were not effective or didn't know.

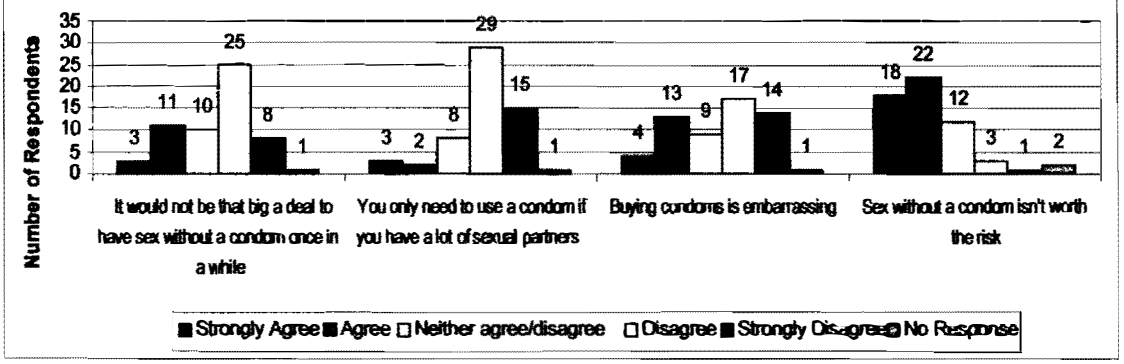
Some notable differences occur between sexually active and non-sexually active young women. There were no non-sexually active young women that thought the pill was very effective at preventing pregnancy; 67% felt it was somewhat effective, 8% felt it was not too effective and 25% didn't know. There also appears to be confusion about how effective condoms are at preventing pregnancy; only 8% felt they were very effective with 84% stating that they were somewhat effective, the remaining 8% didn't know. Finally, only 33% of non-sexually active women though that the condom was very effective at preventing Sexually Transmitted Infections, 59% thought they were somewhat effective and 8% didn't know.

It is clear from these results that more needs to be done to ensure that key messages about the effectiveness of the contraceptive pill and the condom as effective means of preventing pregnancy are communicated. Alongside this, and more importantly, the condom needs further promotion as the most effective means of preventing Sexually Transmitted Infections. These findings are substantiated by other research; for example, the Health Education Authority (1999) found that 25% of young people thought the contraceptive pill protected against Sexually Transmitted Infections.

13.10.2 Condoms - Feelings

Young women were then asked to consider how they felt about condoms in relation to four statements (See Figure 15).

Figure 15: Condoms - Feelings (n=58)



Firstly, respondents were asked to agree or disagree with the statement 'it would not be that big a deal to have sex without a condom once in a while'. 56% (33) of young women disagreed or strongly disagreed with this statement, the remaining 41% (24) either strongly agreed, agreed or neither agreed or disagreed. Notably 23 of the young women in the latter category were already sexually active and only 9 of those young women state that they use contraception and/or protection all of the time. The remaining 14 sometimes do not use contraception/protection and hence practice in line with their opinion, that is, it is not that big a deal to have sex without a condom once in a while.

Next respondents were asked to consider whether they agreed or disagreed with the statement 'you only need to use a condom if you have a lot of sexual partners'. 76% (44) of respondents disagreed or strongly disagreed with this statement. Interestingly of those 44 respondents, 35 were sexually active and of the 35, 26 report they have had sexual intercourse without a condom and 20 reported that the last time they had sexual intercourse they did not use a condom. 22% (13) of young women either strongly agreed, agreed or neither agreed or disagreed with the statement. Of the 13, 10 were sexually active and even though 5 of them have had more than one sexual partner in the past 12 months, none of them used a condom the last time they had sexual

intercourse. This raises the question of what constitutes a lot of sexual partners?

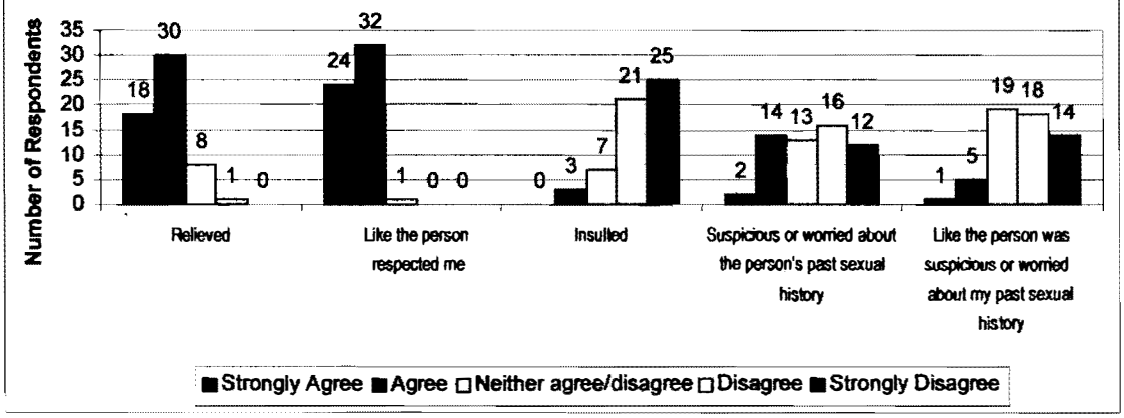
The third statement asked young women to consider whether they agreed or disagreed with the statement 'buying condoms is embarrassing'. Only 29% (17) strongly agreed or agreed with the statement, 53% (31) disagreed or strongly disagreed. This finding leads the researcher to believe that buying condoms is not perceived as embarrassing and is not therefore a barrier to their use.

Finally, respondents were asked to consider whether they agreed or disagreed with the statement 'sex without a condom isn't worth the risk'. The majority of the young women, 69% (40), either strongly agreed or agreed with this statement. Of those 40, 30 reported themselves as sexually active, of the 30, 22 reported that they have had sex without a condom at some time in the past and the last time 17 of them had sexual intercourse they did not use a condom. It would therefore appear that their opinions are not borne out in their practices. Only 27% (26) of respondents either strongly disagreed, disagreed or neither agreed or disagreed.

13.10.3 Condoms - Feelings

Respondents were then asked to consider how they might feel if someone they were having sexual intercourse with, or whom they might have sexual intercourse with, suggested using a condom (See Figure 16). Overwhelmingly respondents reported that they would feel relieved, 83% (48), and that the person respected them, 97% (56). 79% (46) disagreed with the statement that they might feel insulted. Where reporting of feelings became more varied was when respondents were asked about the persons past sexual history, 28% (16) of the respondents agreed or strongly agreed that they might be suspicious of the persons past sexual history. Although 55% (32) of the young women either disagreed with the statement that suggested the partner may be suspicious or worried about their past sexual history, 43% (25) agreed or neither agreed nor disagreed.

Figure 16: Using a Condom - Feelings - (*n*=58)



It is interesting that the majority of young women reported that they would be relieved and feel respected if the person they were having sexual intercourse with suggested using a condom. With such a high response rate one might expect a higher reporting of condoms being used regularly. (This point is discussed later in the report) The researcher is led to assume that if the person is not asked about using a condom and it is not the young women's usual method of contraception, then sexual intercourse proceeds without one. This conclusion is supported by research conducted by Stone & Ingham (2002), who reported that more work needed to be done to develop young peoples' ability to negotiate and discuss sexual and contraceptive decisions.

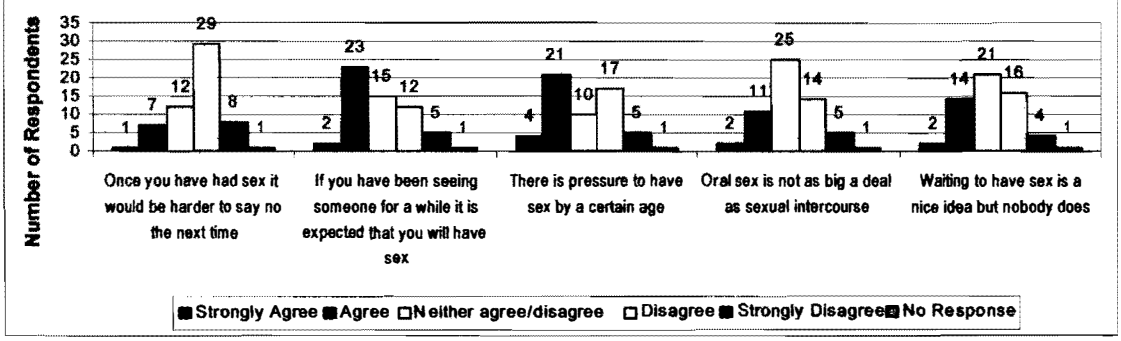
Also, the Counterpoint Research (2001) suggests that although young people are concerned about Sexually Transmitted Infections, which is borne out in this research, they would not use this as an argument to used condoms as it implied they were dirty, promiscuous or both.

13.10.4 Relationships and Becoming Sexually Active

In the final part of this section young people were asked about relationships and becoming sexually active (See Figure 17). 64% (37) of young women disagreed or strongly disagreed with the notion that once you have had sex it is harder to say no next time, however 43% (25) did agree or strongly agree that once you have been seeing someone for a while it is expected that you will have sex. 43% (25) of young women agreed or strongly agreed that there is pressure to have sex by a certain age. Notably all 25 were already sexually active and 56% (14) of them first had sexual intercourse under the age of 16, a further 32% (8) of them had sexual intercourse at the age of 16.

Interestingly, 43% (25) of respondents neither agreed nor disagreed that oral sex was not as big a deal as sexual intercourse. 22% (13) agreed or strongly agreed with the statement. This could suggest that there is a view that oral sex is not such a big deal as only 33% (19) of respondents disagreed or strongly disagreed with the statement. 34% (20) of the young women reported that they felt people did wait until they had sexual intercourse as opposed to the 27% (16) who didn't think that people waited, however, 36% (21) of young women neither agreed nor disagreed. Proportionately responses between sexually active and non-sexually active young women were similar.

Figure 17: Relationships and Becoming Sexually Active - Feelings (*n*=58)

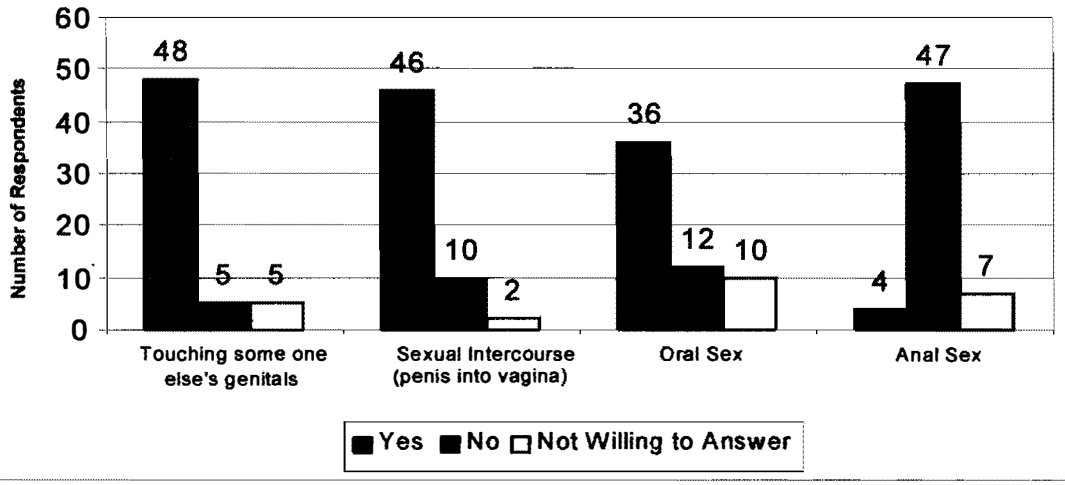


13.11 Sexual Experience(s) and Contraceptive Usage

13.11.1 Sexual Activities

The research then went on to consider types of sexual activities, as reflected in Figure 18. 83% (48) of respondents have been involved in touching sexual partners genitals, 79% (46) have had sexual intercourse, 62% (36) have been involved in oral sex and 7% (4) have had anal sex. Even though 21% (12) of the young women stated they were not sexually active they reported forms of sexual activity. Of the 12 non-sexually active young women, 58% (7) had touched partner's genitals and 25% (3) had been involved in oral sex. Of those reporting that they are not yet sexually active 7 were aged 16 and 5 aged 17.

Figure 18: Types of Sexual Activity (*n*=58)



At this point in the questionnaire a filter question was added and only those that reported themselves as sexually active, which was 79% (46) of the respondents, continued with the questionnaire. From this point onwards the analysis and discussion is linked to those 46 (100%) women who reported themselves as sexually active. Figure 1, discussed previously, can be used as an aide memoire for how the respondents self reported their sexual orientation and sexual status.

13.11.2 Age at First Sexual Intercourse

The young women were asked to disclose the age at which they became sexually active. As can be see in Table 2, 50% (23) of them became sexually active under the age of 16, 36% (17) at the age of 16, 7% (3) at the age of 17, 7% (3) at the age of 18, and by the age of 19 all respondents were sexually active.

Table 2: First Sexual Intercourse - Age (*n*=46)

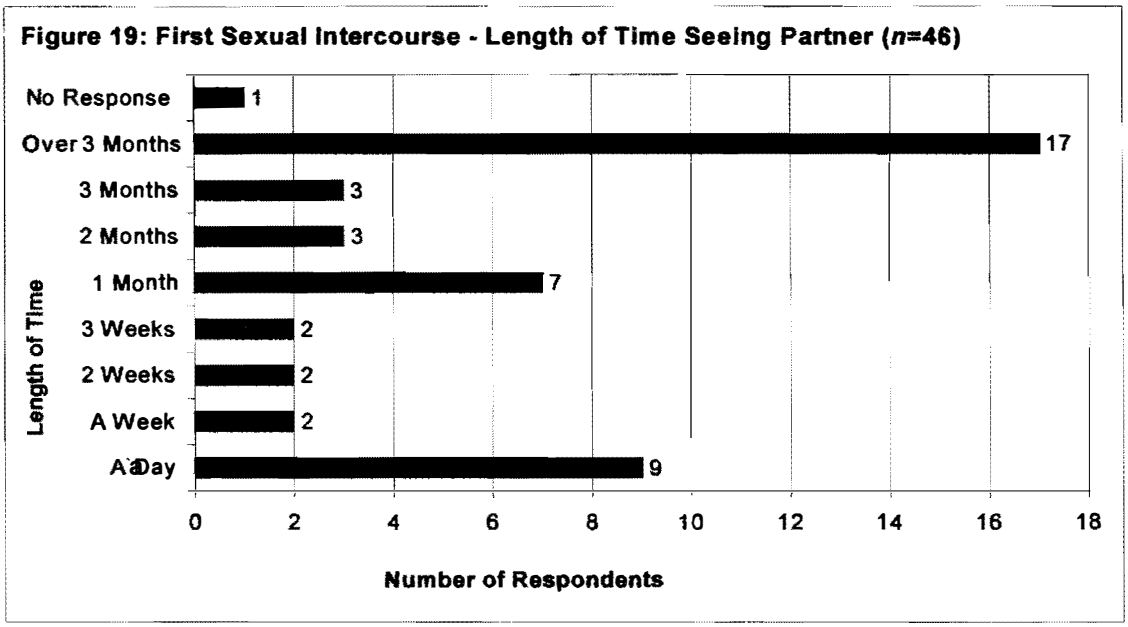
Age	*n*	per cent
Under 16	23	50%
16	17	36%
17	3	7%
18	3	7%
19	0	0%
Total	46	100%

As has been discussed previously the rate of those young women reporting themselves as sexually active was much higher than expected. What is also higher than anticipated is the number of young women reporting sexual activity under the age of 16. The median age for first sexual intercourse in the UK is now 16, Tripp & Viner (2005), and in a recent study the BBC (2006) reported that seven out of ten (70%) young people now wait until they are at least 16 to lose their virginity. It would appear that this group of young women differ from the national average, as for them, the median age of intercourse is somewhere under the age of 16, and only 50% of them waited until they were at least 16 to become sexually active. Compared to the rest of the UK, more of them are having sex and at a younger age.

13.11.3 Length of Time Seeing Partner before First Sexual Experience

In order to gain insight into the stability of relationships prior to first sexual intercourse, participants were asked to report how long they had 'been seeing' their first partner before having sexual intercourse (See Figure 19). 20% (9) of respondents reported only seeing their partner for one day. There does appear to be a correlation between age of first sexual intercourse and the length of time seeing your partner. Of the 9 who reported sexual intercourse within a day, 7 of them were under the age of 16. A further 28% (13) reported seeing their partner between one day and one month, with only 37% (17) of young women waiting over 3 months before having sexual intercourse.

Figure 19: First Sexual Intercourse - Length of Time Seeing Partner (*n*=46)



Research conducted by Brook (2000), reports that the overall median time of seeing a partner before having sexual intercourse is 12 weeks or 3 months. In their research, 25% of young women engaged in sexual intercourse within three weeks, 50% delayed for 3 months and 25% delayed for at least 6 months. Comparing these findings, it would appear that the young women in this research are engaging in sexual intercourse having 'been seeing' their partner for a shorter length of time, for example, 20% of young women had sexual intercourse within the first day as compared to 10% in the Brook research, also 33 % had sexual intercourse within 3 weeks as compared to 25% in the Brook research. Furthermore, as with this research, Brook also showed a relationship between age at first sexual intercourse and length of

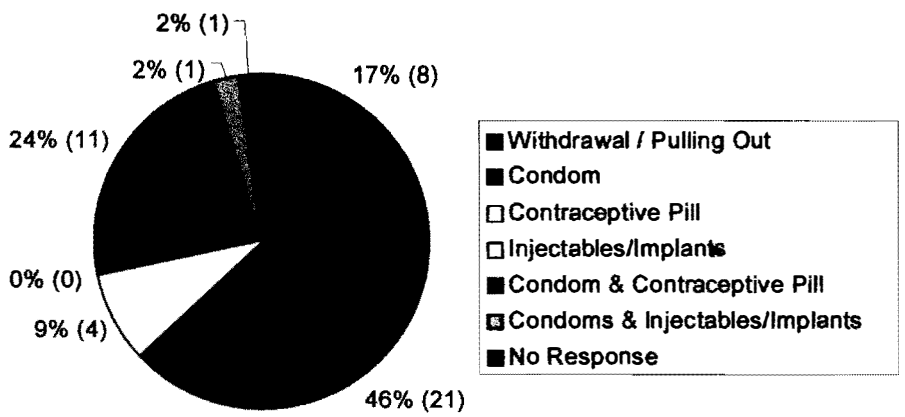
time seeing a partner, in essence, the younger the individual at reported first sex the shorter the time they will see each other before having sexual intercourse.

13.11.4 Contraceptive Usage at First Sexual Experience

Much research has been conducted about the use of contraception at first sexual intercourse, findings from Tripp & Viner (2005) suggest that 33% of young people aged 16-19 used no contraception the first time they have sexual intercourse, whereas more recent research by the BBC (2006), with over 30,000 respondents, reported that 25% of 16-24 year olds used no contraception the first time they had sexual intercourse.

At first sexual intercourse, 72% (33) of the young women reported that they used either a condom on it's own or a condom with some other form of contraception. 9% (4) of the young women used a form of contraception other than a condom and 17% (8) used no contraception/protection at all (See Figure 20). This means that 26% (12) of the young women put themselves at risk of catching a Sexually Transmitted Infection. Of those, 17% were also at risk of becoming pregnant, whilst leaving themselves vulnerable to Sexually Transmitted Infections. Although a slightly higher proportion of young women in this research used some form of contraception / protection, 81% (37), a significant proportion of women, 17% (8), still left themselves at risk. All except one were under the age of 16.

Figure 20: First Sexual Intercourse - Contraceptive Used (*n*=46)



The 46% (12) of young women that had sex for the first time without a condom stated the following as reasons why (multiple answers were permitted):

- Sex suddenly happened (7)
- Condom was not available at the time (3)
- Partner insisted not to use one (1)
- Didn't know how to use one (1)

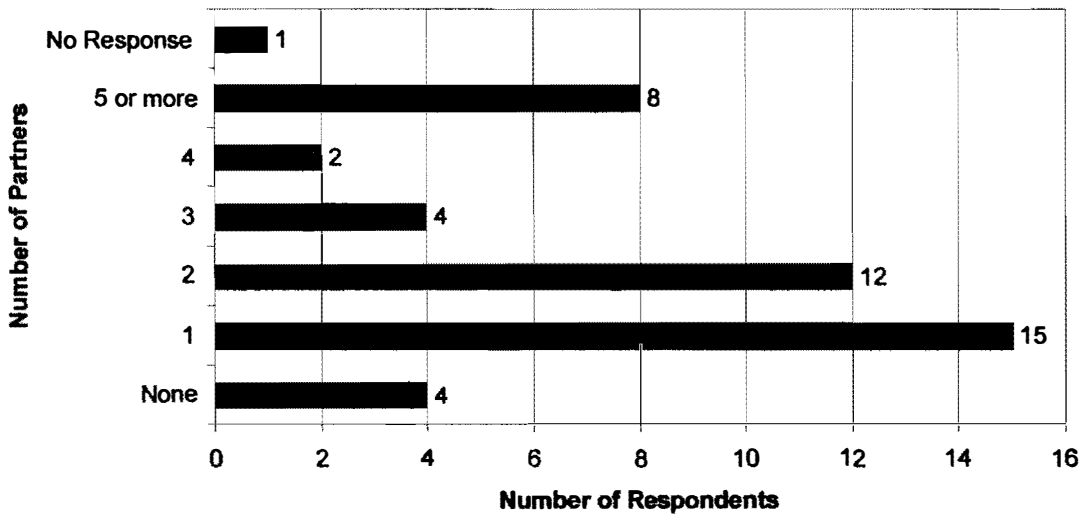
Counterpoint Research (2001), describes that many young women commonly report 'sex suddenly happened' as a reason for not using a condom, for many, they were not planning to have sex and therefore didn't plan contraception. Notably, the seven young women who cite this as a reason all became sexually active under the age of 16.

13.11.5 Number of Sexual Partners in the Last 12 Months

Research by The Royal Institute of Public Health (2006) suggests that there has been a change in sexual behaviour in recent years, more people are having sex with more partners and much of this sexual activity is unprotected. Only 33% (15) of young women reported having only one sexual partner within the past 12 months (See Figure 21). More, 40% (18), reported between two and four partners and 17% (8) reported having had five or more sexual partners within the past 12 months. Of the 8 who reported five or more partners, only 1 used a condom the last time they had sexual intercourse.

Also noted from the analysis is that of the 46 sexually active young women, 34 of them have had sexual intercourse without a condom. Of the 34, 62% (21) have had 2 or more sexual partners, greatly increasing their risk of acquiring a Sexually Transmitted Infection. Even the 38% (13) who report only having had one sexual partner and having sex without a condom at sometime are putting themselves at risk. That is unless both they are their partner were virgins the first time they had sexual intercourse and their partner has not since has sexual intercourse with another person.

Figure 21: Number of Sexual Partners in the Last 12 Months (*n*=46)

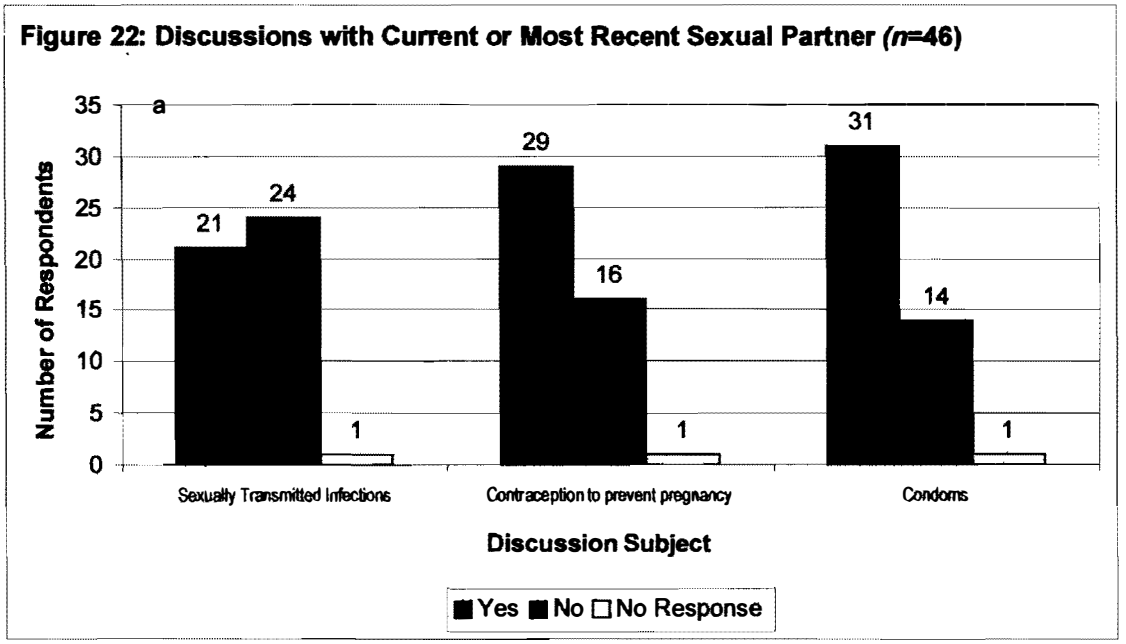


13.11.6 Discussing Contraception And Protection With Partners

From this research it is apparent that not all young women discuss contraception and protection with their partners (See Figure 22). Only 46% (21) of respondents discussed Sexually Transmitted Infections with their current or most recent sexual partner, however a much higher proportion did discuss contraception to prevent pregnancy, 83% (29). It would appear from these results that pregnancy is more of a worry than catching a Sexually Transmitted Infection. Interestingly a higher proportion did discuss condoms, 67% (31), than Sexually Transmitted Infections, however it is not clear if this discussion was focused on condoms to prevent pregnancy or condoms to prevent Sexually Transmitted Infections.

Chambers & Rew (2003) reiterate that young women are at risk of unintended pregnancies and Sexually Transmitted Infections if they do not engage in safer sexual practices. What they found, however, is that young women need to develop their skills of communication to enable them to negotiate condom use with partner(s).

Figure 22: Discussions with Current or Most Recent Sexual Partner (*n*=46)



13.11.7 Frequency of Use of Contraception/Protection

When asked how often contraception / protection was used during sexual intercourse, 59% (27) of the young women reported that they used contraception / protection all of the time, however, 26% (12) of young women reported that they used it most of time with a further 11% (5) reporting that they only used it some of the time. 4% (2) of the young women reported never using contraception / protection. It is clear from these responses that the messages about contraceptive use and the additional need for protection are not being practiced. When Lindsay et al (1999) conducted their research they confirmed that young people were being exposed to two potentially conflicting messages, one, which emphasised the prevention of Sexually Transmitted Infections and the other stressing pregnancy prevention. They concluded, and this research supports this, that young women need to be educated about the distinction between safer sex and contraception and how to prevent both Sexually Transmitted Infections and pregnancy.

13.11.8 Types Of Contraception Ever Used

Figure 23 shows the types of contraception that the young women reported ever having used. As can be seen the condom on its own is the most popular with 83% (38) of young women reporting this as a method used. 63% (29) reported using the contraceptive pill on its own and 59% (27) report the combined use of the pill and the condom. This combined method, known as Double Dutch, is recognised as one of the safest options. If used properly together they prevent pregnancy and protect against Sexually Transmitted Infections. The other recommended option would be Condoms and either injectables or implants together. Worryingly, 33% (15) of the young women have relied on withdrawing or pulling out. A method, that offers no prevention of pregnancy or protection against Sexually Transmitted Infections.

Figure 23: Methods of Contraception Used (*n*=46)

Only 26% (12) of the young women reported never having had sex without a condom, meaning that 74% (34) had exposed themselves to the risk of sexually transmitted infections at some point in the past. Reasons reported for having sex without a condom were as follows (multiple responses were permitted):

- Sex suddenly happened (5)
- Condom reduces pleasure (3)
- Condom not available (4)

- Partner insisted not to use one (1)
- Didn't know how to use one (1)
- Cost (2)
- Would interrupt sex (3)
- Other contraception used (20)

Respondents were then questioned about the last time they had sexual intercourse and whether or not they used a condom, 61% (28) reported not using a condom. Reasons reported for having sex without a condom the last time sexual intercourse took place were as follows (multiple responses were permitted):

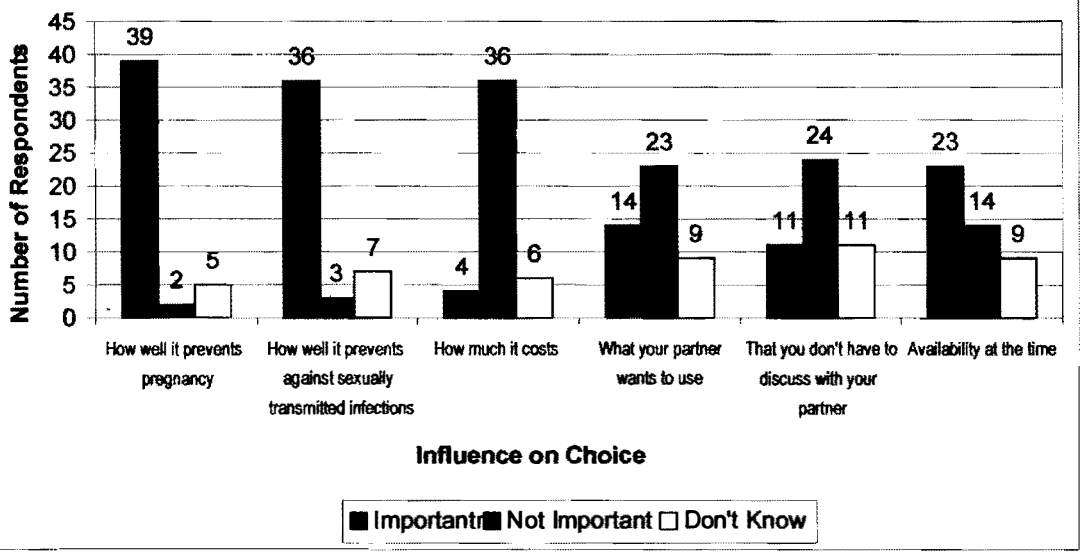
- Sex suddenly happened (6)
- Condom reduces pleasure (4)
- Condom not available (2)
- Would interrupt sex (1)
- Other contraception used (15)

Notably one of the most common reasons reported for not using a condom is that another form of contraception was used; this was the case in this research. Although this prevents pregnancy there is no protection against Sexually Transmitted Infections.

13.11.9 What Influences Contraception Choice

When questioned about what influences contraceptive choice, what is clear is that young women report that they are keen to avoid pregnancy, 85% (39), and also prevent Sexually Transmitted Infections, 78% (36) (See Figure 24). However, when analysing the results it is apparent that this ideal is not always followed through into practice. Of the 78% (36) of young women stating that the prevention of Sexually Transmitted Infections was important, 26 of them have had sexual intercourse without using a condom and 21 of them did not use a condom the last time they had sexual intercourse. It would appear that availability at the time is also a consideration, reported as important by 50% (23) of the young women.

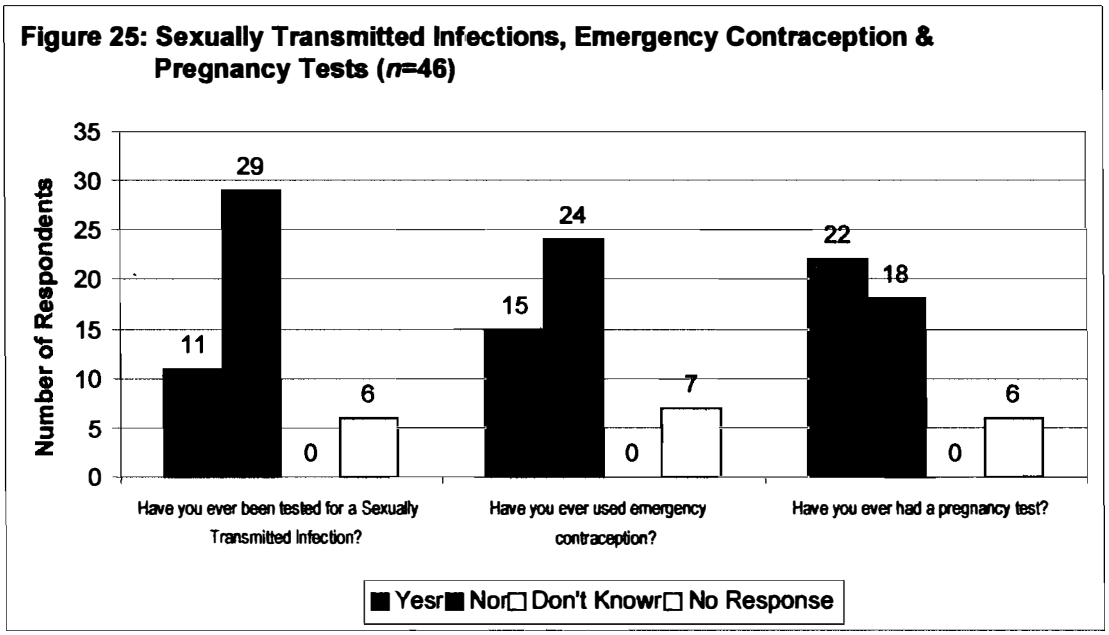
Figure 24: Influences on Contraceptive Choice (*n*=46)



13.12 Sexually Transmitted Infections and Emergency Contraception

Figure 25 shows that of the sexually active young women, 24 % (11) have been tested for a Sexually Transmitted Infection; all reported that the test was negative. However, on analysing the data further, 3 of the 11 young women reported that last time they had sexual intercourse they did not use a condom. Further research would be required around this area to ascertain what understanding the young women had regarding the prevention of Sexually Transmitted Infections following their tests. 33% (15) of the young women have used emergency contraception and of the 48% (22) of young women reporting having had a pregnancy test, 2 of them tested positive. As would be expected, many of the young women that have used emergency contraception or have had a pregnancy test have used 'no contraception' at some point in the past, that is, they have relied on the withdrawal/pulling out method.

Figure 25: Sexually Transmitted Infections, Emergency Contraception & Pregnancy Tests (*n*=46)

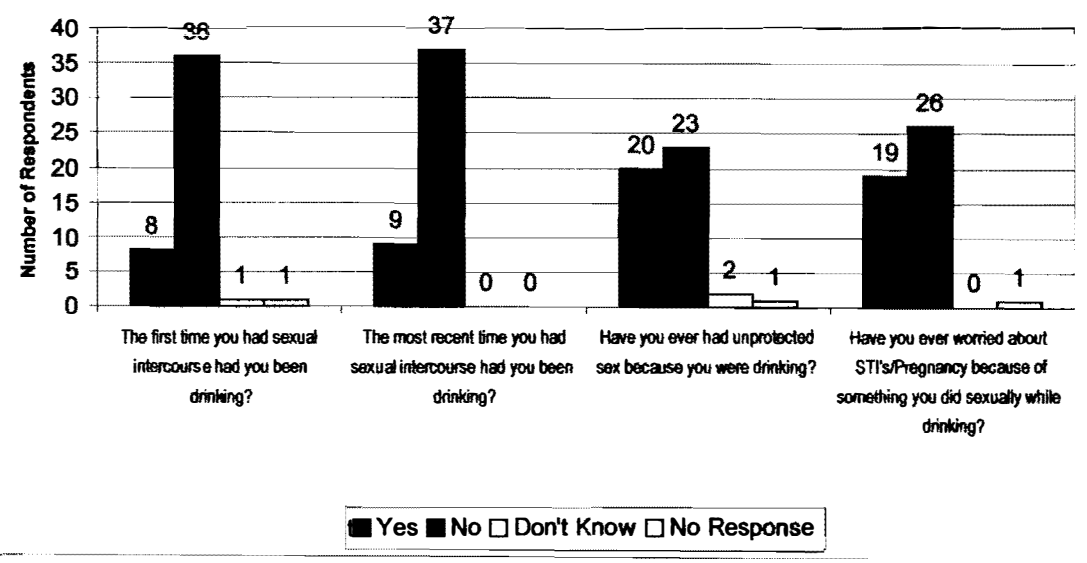


13.13 Sexual Activity and Alcohol

Much research is now focused on the role of alcohol in relation to sexual intercourse and sexual health. Reports vary regarding the percentage of young people under the influence of alcohol at the time of their first sexual experience. The research conducted by the BBC (2006) suggests that 33% of young people had been drinking the first time they had sex, and Ingham et al (2001) report that 13% of young women had been under the influence of alcohol when they lost their virginity. The results for this research, see figure 26, show that 17% (8) of the young women had been drinking the first time they had sexual intercourse. Of the 8, 5 of them used no contraception or protection and 6 of them were under the age of 16. Clearly there are many risks associated with the combination of first sexual intercourse and alcohol intake, not least getting pregnant or catching a Sexually Transmitted Infection.

What is clear from the research is that alcohol has led some young women to do things or put themselves at risk because they had been drinking. 43% (20) of the young women report having had unprotected sex because of alcohol and 41% (19) have worried about Sexually Transmitted Infections or pregnancy because of something they did whilst under the influence of alcohol. Looking at most recent sexual experiences 20% (9) of young women reported that they had been drinking.

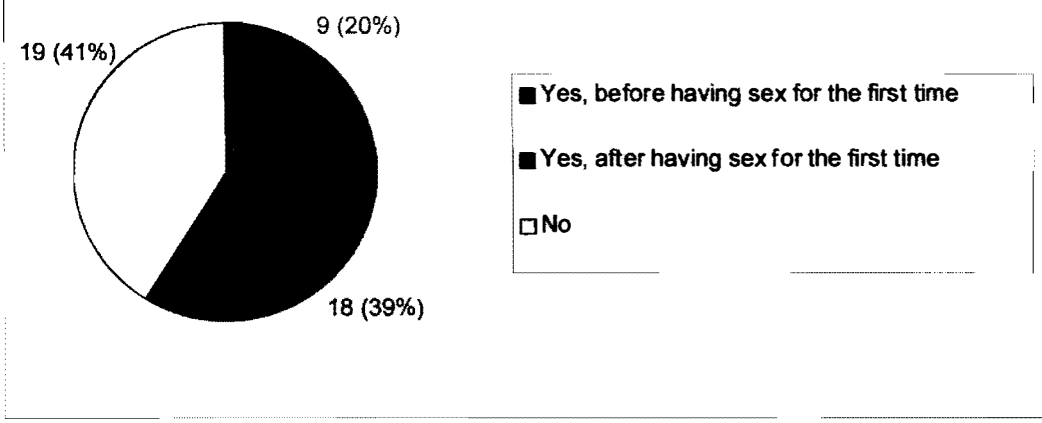
Figure 26: Sexual Activity and Alcohol *(n=46)*



13.14 Usage of Sexual Health Services

Only 20% (9) of sexually active young women reported visiting a sexual health service prior to becoming sexually active, 39% (18) visited after first sexual intercourse and 41% (19) reported never having visited any form of sexual health service (See Figure 27).

Figure 27: Sexual Health Service Usage (*n*=46)



Those using a sexual health service, 59% (28), reported attending the following venues (multiple answers were permitted):

- School Based Health Service (7)
- Specialist Service for Young People (11)
- Family Planning Service (2)
- Doctor (10)

Of those visiting a sexual health service **before** they became sexually active, 20% (9), the following reasons were given for attending (multiple answers were permitted):

- To be prepared (8)
- Out of curiosity (2)
- They planned to have sex soon (10)
- To obtain advice and information (3)
- Other reason (10)

These responses bear out in both this research and in other research, as those that attended a sexual health service prior to first sexual activity did in fact proportionately practice safer sex, of the 9, 7 protected themselves from both pregnancy and Sexually Transmitted Infections and one from pregnancy, however one still went on to have sex without any form of contraception or protection. Brook (2000) also found that young women that visited a sexual health service prior to first sexual intercourse then went on to be better prepared in relation to avoiding pregnancy and preventing sexually transmitted infections.

When questioned, those that **didn't visit before** they had sexual intercourse, 39% (18), reported the following reasons (multiple answers were permitted):

- They didn't plan to have sex (8)
- They got condoms from another source (4)
- They were worried about confidentiality (2)
- They didn't think about it (4)
- They were worried about their age (2)
- They were embarrassed (3)
- It would have been difficult to get there (1)

When questioned about why they then did visit, **after** having sex, they reported the following reasons (multiple answers permitted):

- To be prepared for next time (2)
- To get condoms (9)
- To discuss and switch method of contraception (6)
- They had unprotected sex (6)
- Worried about STI's (2)
- Worried about pregnancy (7)
- Contraceptive failure (1)
- Pregnancy Test (6)
- Emergency contraception (3)

Reasons for visiting a sexual health services are very similar, and highlight no surprises, to those results reported within the Brook (2000) research. These results can be viewed from two perspectives. There appears to be a group of young people that on realising they are sexually active want to be prepared for the next time and ensure that their contraceptive and sexual health needs are discussed and met. There also appears to be a group of young people who, having had sexual intercourse have put themselves at risk and require support, advice and possible treatment in relation to pregnancy and sexually transmitted infections.

It is clear that work is required with young people before they become sexually active to encourage them to access sexual health services. Young people need to be realistic about the possibility that they may have sex and that they need to be prepared for when the time comes.

14.0 Conclusion

This study builds on existing research and establishes what 16-19 year old young women know about contraception and sexual health and compares the relationship between knowledge and practice of those who are sexually active. For the majority of young people, education about sex and relationships begins at school. As young people mature, the education they receive should develop to meet their needs. Ultimately, on leaving school, young people should be prepared for an adult life where they have the knowledge and skills to enable them to protect themselves from unintended pregnancy and sexually transmitted infections. What is clear from this research is that for many young women this is not in fact the case. Many report not having received Sex & Relationship Education at school, and of those who do recall receiving it, the majority state that it was neither interesting nor relevant.

The overwhelming majority, eight out of ten, of young women involved in this research were sexually active. By comparison, the rates of sexual activity were higher than that of the UK average and the proportion of those young women that became sexually active under the age of 16 was also higher than the UK average.

The majority of young women reported that they knew 'only a little' about Sexually Transmitted Infections; this was borne out as knowledge levels were tested. Just under half of the young women thought that they would always be aware if they had a Sexually Transmitted Infection, a smaller proportion thought that they would always be aware if someone they were dating had a Sexually Transmitted Infection and some believed that Sexually Transmitted Infections could only be spread when symptoms were present and obvious. Although the large majority of young women recognised that they should be concerned about Sexually Transmitted Infections even if they had not had a lot of sexual partners, of those that were sexually active, the majority, eight out of ten, have had sexual intercourse without a condom.

All respondents had heard of the Sexually Transmitted Infection Chlamydia, however a quarter of the young women did not know that it could cause infertility in women, half of them thought that it was only women that could become infected and three quarters of them did not know that symptoms may not be displayed. When asked

what the most effective way was to protect oneself from Chlamydia, two out of ten young women did not know the answer.

Generally, knowledge levels about the risk of becoming pregnant were higher. All respondents were aware that you could become pregnant the first time you had sex, despite this, a number of the young women had unprotected sex the first time they had sexual intercourse. Confusion arose when questioned about the likelihood of sperm coming out a mans penis prior to ejaculation, three out of ten young women answered this question wrongly. Only seven out of ten young women knew that it would be possible to get pregnant if the man withdraws before ejaculation. All of the young women had heard of emergency contraception, however, a quarter of the young women did not know that it was possible for it to be used up to 72 hours after unprotected sex or contraceptive failure.

There was distinct misunderstanding about the effectiveness of oral contraceptive pills and condoms and how each of them could prevent pregnancy and protect against Sexually Transmitted Infections. Only four out of ten young women thought that the oral contraceptive pill was very effective at preventing pregnancy, more, five out of ten, thought that it was only somewhat effective. When questioned about the condom, three out of ten young women thought that it was very effective at preventing pregnancy, however, almost seven out of ten thought it to be only somewhat effective. In relation to the prevention of Sexually Transmitted Infections, three out of ten young women thought that oral contraception would effectively prevent Sexually Transmitted Infections. Of concern, only five out of ten young women knew that the condom was very effective at preventing Sexually Transmitted Infections.

Only half of the young women agreed that it would be a big deal to have sex without a condom once in a while. When questioned as to whether condoms only needed to be used if you have sex with a lot of sexual partners, eight out of ten young women disagreed. Interestingly, of those sexually active young women disagreeing with this statement, three quarters have had sexual intercourse without a condom and just over half of them had sex without a condom last time they had intercourse. Three quarters of the young women were of the opinion that sex without a condom wouldn't

be worth the risk however, as was demonstrated, condom use is not always consistent with opinion. The purchase of condoms would not appear to be a barrier to their use; only three in ten young women reported that they might be embarrassed if buying them.

The overwhelming majority of young women reported that they would be relieved and feel respected if the person they were having sexual intercourse with, or were planning to have sexual intercourse with, asked that they used a condom. However, there was a feeling from three out of ten young women that they would be suspicious of their partners past sexual history. Four out of ten young women also thought that the person might be worried about their past sexual history.

There is a feeling amongst half of the young women that once you have been seeing someone for a while there is an expectation that you will have sexual intercourse and become sexually active by a certain age, however the majority felt that once you have had sex once, it is easier to say no the next time. Notably, in relation to these feelings, of those that were sexually active, nearly six in ten had had sexual intercourse before they were sixteen and three in ten at the age of sixteen.

The remainder of the findings relate to those young women that were sexually active. Two in ten young women reported only seeing their partner for one day before their first sexual experience, the majority of these were under the age of 16. Three in ten saw their partner between a week and one month, two in ten between one and two months and only three in ten young women waited until they had been seeing their partner for over three months before their first sexual experience. At first sexual experience two in ten young women used no contraception at all and fewer than one in ten used a form of contraception other than the pill, thus protecting themselves from pregnancy but not Sexually Transmitted Infections. The most common reason stated for not using a condom at first sexual intercourse was that sex suddenly happened, this was followed by the fact that a condom was not available at the time.

Only three in ten young women report having had only one sexual partner within the past 12 months. Four in ten report between two and four partners and with the remainder reporting five or more sexual partners. With these facts in mind, only a

quarter of the young women report never having had sex without a condom. The large majority of young women, eight out of ten, reported that they discussed contraception to prevent pregnancy with their current or most recent sexual partner, just under seven out of ten discussed condoms and less, under half, discussed Sexually Transmitted Infections. Worryingly, only six out of ten young women reported using contraception/protection all of the time, a quarter used it most of the time and the remainder either used it some of the time or never. Although a combined method, for example, the contraceptive pill and the condom together, is recommended as effective for young people, just over half of the young women reported ever having used these together. Over a third of young women report having relied on the withdrawal method. Notably the most common reason stated for not using a condom in some that some other form of contraception was used. Although this prevents pregnancy there is no protection against Sexually Transmitted Infections.

Influences on contraceptive choices, were overwhelmingly, a desire to prevent pregnancy, with nearly nine in ten young women reporting this as a reason, and a wish to prevent Sexually Transmitted Infections, just under eight in ten young women stated this as an important reason for their choice. However, three quarters of the young women stating that they wanted to prevent Sexually Transmitted Infections have had sexual intercourse without a condom and two thirds of them had sexual intercourse without a condom last time they had sex. Half of the young women also reported that availability of contraception, at the time of intercourse, was also important.

A lower proportion of young women than expected, less than two in ten, reported that they had been drinking the first time they had sexual intercourse however, just under a quarter of young women reported that they had been drinking the last time they had sexual intercourse. Four in ten young women report having had unprotected sex because of alcohol and being worried about Sexually Transmitted Infections and pregnancy. Although not necessarily linked to alcohol, a quarter of the sexually active young women have been tested for a Sexually Transmitted Infection, a third have used emergency contraception and nearly half have taken a pregnancy test.

Finally, only two in ten sexually active young women report having visited a sexual health service prior to their first sexual experience. Services visited included; Specialist Services for Young People, Doctors, School Based Health Services and Family Planning Services. These young women reported that they want to be prepared as they planned to have sex soon. Reasons given for not visiting prior to becoming sexually active were; they didn't plan to have sex, they got condoms from another source, they were worried about confidentiality, they were embarrassed and they were worried about their age.

Four in ten young women visited a sexual health service after their first sexual experience. Those visiting can be split in to two distinct groups; those that wanted to be prepared for the next time, get condoms and discuss their contraception needs and those that were worried about Sexually Transmitted Infections and pregnancy because they had had unprotected sex or a contraceptive failure. The remainder of sexually active young women, four in ten, had never used a sexual health service.

- **Limitations**

The main limitation of this study is that the researcher was unable to compare knowledge levels and opinions between sexually active and non-sexually active young women, as the number of those that were not yet sexually active was very low. That said, this limitation in itself added value to the research and the findings as it highlighted the unexpectedly high proportion of sexually active young women. Although not tested for statistical significance, the researcher is confident that the findings are sound and can be used to develop proposals for further research and recommendations for policy makers and service providers.

- **Recommendations**

Following this quantitative analysis it would be appropriate to develop and test the themes that have emerged utilising a qualitative approach. Further exploration is recommended in the following areas:

- Sex & Relationship Education – what knowledge do young people need when leaving school, specifically in relation to preventing pregnancy and protecting themselves from Sexually Transmitted Infections, and how do we strive to meet their needs and make Sex & Relationship Education relevant and interesting?

- What other mechanisms exist to work with young people, which would give them opportunities to develop their knowledge and understanding about being sexually healthy? It is clear that Sex and Relationship Education should not stop once a young person has left school.

Recommendations for Policy Makers and Service Providers

- All schools should be delivering a planned Sex & Relationship Education Programme that is developed throughout each year group and meets the varied needs of young people.
- School Based Health Services need to be promoted as venues that can offer advice and support on a range of sexual health issues and that young women might use them in preparation for becoming sexually active.
- More emphasis needs to be given to education regarding Sexually Transmitted Infections, in particular Chlamydia, and their prevention. This education should happen in all appropriate venues where young people attend.
- Awareness needs to raised regarding emergency contraception and the fact that young women have up to 72 hour after unprotected sex or contraceptive failure to access it.
- For all those working with young people, a clear distinction needs to be made between contraception and protection and the use of both methods together should to be promoted with young people.
- Young people should be given the opportunity to practice negotiation and communication skills, particularly around developing their confidence in requesting the use of condoms with sexual partners.
- Young people need to be educated to understand the consequences of mixing sexual activity with alcohol.
- Young people need to be encouraged to access Sexual Health Services prior to becoming sexually active.

This research clearly demonstrates that although young women are of the opinion that they would like to prevent pregnancies and protect themselves from Sexually Transmitted Infections, they do not have the knowledge that allows them to practice 'safe sex' and thus look after both their reproductive health and sexual health.

15.0 Dissemination of Results

Boynton (2005:153) states that all too often researchers never disseminate their findings. Having worked with young people to undertake this research, both in relation to developing and piloting the survey and in generating the data, it is essential that the results be disseminated. This is not only in the hope that the findings impact on practice, but also to recognise the contribution that young people have made in an area of research that is of particular relevance to them. Alongside this, a number of health and education colleagues that were involved in the consultation for the data collection tool showed an interest in the findings.

Due to the nature of the research, the findings of which are likely to be of particular interest to the media, it is essential to ensure that the contribution the young people made is portrayed in a positive light. The dissemination of the findings will emphasise that the research was undertaken to have a beneficial impact on the way services are delivered to young people in the future, thus enabling them to make positive and informed choices around their sexual health and contraceptive choices.

Having now completed the research an Executive Summary (ES) and a multi-media presentation (P) will be produced to support the dissemination of the results over the coming months. The Executive Summary will be sent to a range of stakeholders; alongside this a range of professionals will be targeted and invited to view the presentation at pre-arranged sessions.

Research findings are to be disseminated to the following:

- Northamptonshire PCT Board (ES & P)
- Further Education College & Local Young Persons Sexual Health Service (ES)
- PCT Public Health Department (ES & P)
- Primary Care Staff including GP's and School Health Nurses (ES & P)
- Family Planning / GUM Service (ES)
- Annual Teenage Pregnancy Conference (ES & P)
- Chlamydia Screening Manager and Officers (ES & P)
- PCT Communication Manager (ES)

Finally, following the guidance discussed by Polgar & Thomas (2003:272), work is underway to publish the research in a range of journals with particular relevance to young people and sexual health, for example, Education and Health, which is published by the Schools Health Education Unit (SHEU) and SHINE, the Sexual Health Information New Exchange, published by The Centre for HIV and Sexual Health.

16.0 Reflection of Learning

A range of models exist which enable practitioners to reflect on their work. I have chosen to utilise "Gibbs Reflective Cycle Model" (University of Luton, 2004).

Having now completed my dissertation I feel a great sense of not only pride but also relief. Although I wrote my research proposal during February 2006, it is not really until the last few months that I have moved towards completing my research by developing a data collection tool, collecting the data, analysing the results and writing up my findings. During this period I have had times when I felt that I was progressing well, however I have also had overwhelming periods when I felt that I was taking one step forward and two steps backwards, particularly in relation to securing NHS approval to proceed with the research and also in receiving completed questionnaires to enable me to proceed with my data analysis. In addition, during the last few months the NHS has gone though particularly turbulent times and I have felt the effects of the amalgamation of three Primary Care Trusts into one Primary Care Trust by having both my management role at work significantly changed and a new management structure imposed.

I feel that I have gained particularly from the experience of active research. Having never undertaken this type of work before I now realise that I am able to time manage my workload both professionally and personally, I have skills in questionnaire design and development and my negotiation and prioritisation skills have come to the forefront, not to mention my ability to stay self-motivated. What I have however realised is that as a sole researcher many of the areas required to progress the work are very much out of your control, not a situation I am comfortable with. Having said that, what I did comprehend very early on was that I would need to call on my health promotion specialist skills and not only identify key people and partners that could support me with the research but also engage and involve my target audience to design and pilot my questionnaire. I did at times feel that I was working in isolation, particularly as this piece of work was being carried out independently of my professional role and within my own time. I have found that it is much easier for me to ask others for help and support in a professional capacity as opposed to a personal capacity.

However, as the months have progressed, by conducting my literature review, carrying out the research and having discussions with various colleges I really feel that I have consolidated my learning and developed increased knowledge particularly around Chlamydia and young peoples attitudes to their own sexual health. Having successfully completed all of the taught modules for the MSc in Public Health I am aware that I have been able to put theory into practice, particularly in relation to my understanding of research methodologies and methods.

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19.0 Appendices

A Letteri– Seeking approval from Further Education College

B Letter – Approval Granted from Further Education College

C Data Collection Tool

D Participant Information Sheet

E E-mail – Seeking clarity regarding NHS Ethics Committee approval

F Letter - Approval from NHS Ethics Committee to conduct research

G Application Formi– NHS Research and Development

H Letter - Approval from NHS Research and Development

I Tutor Information Sheet

J Letter – Seeking approval from DSN Primary Care Trust

K Letter – Seeking approval from PCT Line Manager

L Letter – Approval Granted from DSN Primary Care Trust

M Letter – Approval Granted from PCT Line Manager

N Letter – Seeking approval from Time2Talk

O E-mail – Approval Granted from Time2Talk

P Projected Research Budget

Q Research Timetable – From original research proposal

R Research Timetable – Actual

S Extract of Coding Frame Worksheet

T Results recorded by Sexually Active & Non-Sexually Active Young Women

Appendix A: Letter – Seeking approval from Further Education College

16th October 2006

John Underwood

Dear John

Re: MSc Public Health – Research / Dissertation

Thank you for agreeing to meet with me prior to the summer holidays regarding my proposed research. As you will recall I am currently studying for my Masters in Public Health at The University of Bedfordshire and in order to complete my Masters Degree I am required to undertake research that I can write up as my dissertation. Having submitted my research proposal to the university for approval I have received confirmation that they are happy for me to proceed and conduct my research.

Although I will be conducting my research and writing my dissertation in a personal capacity I have been granted permission from Kevin Herbert and Carole Dehghani from the former Daventry & South Northants Primary Care Trust to conduct the research. As mentioned at our meeting, I am an employee of the PCT and have worked as the Acting Public Health Manager. Since the formation of the new Northamptonshire PCT on the 1st October 2006 I have returned to my substantive post of Healthy Schools Programme Manger.

As we discussed it is anticipated that the research findings will be of interest to the College, Time2Talk and the PCT and I would therefore anticipate that the findings will be made available to support any future development of Young Peoples' Sexual Health Services both locally and across the County.

I would like to take this opportunity to confirm the area of my research and I have enclosed my abstract as an aide memoire:

> ***The Research Abstract:*** *This research will generate local baseline information about the methods of contraception that 16 - 19 year old young women use, or don't use, and the rationale for their choices. Utilising survey methodology all 16-19 year old young women attending the local Further Education College will be invited to complete an anonymous and confidential questionnaire. The questionnaire will be designed and piloted by young people known to the local Young Persons Sexual Health Service. Following the collection of quantitative data, if required, focus groups and in-depth interviews will be held to consolidate the results. In essence this research will establish what knowledge young women have about preventing pregnancy and Sexually Transmitted Infections (STI's) and determine how and why they put, or don't put, this knowledge into practice.*

For your information I have contacted the Local Research Ethics Committee and they have confirmed, in writing, that it will not be necessary for me to gain ethics Committee approval in order to conduct the research.

At our meeting you gave verbal approval for me to conduct my research with your full-time female students aged between 16 and 19 years. You also suggested that a member of staff from your Learners Support Centre would be best placed to support me make contact with the relevant students and define a mechanism for distributing my confidential questionnaire.

I am in the final process of developing the questionnaire and I envisage that it will be ready for distribution and completion during November. I would therefore be grateful if you would confirm in writing that Northampton College remains supportive of my research and is happy for me to proceed. I would also be grateful if you would provide me with the details of the member of staff within your Learners Support Centre that I should contact.

I would like to thank you for your support to date and look forward to hearing from you in the near future.

Yours sincerely

Adrienne Hand (Nee Jarrett)

Appendix B: Letter – Approval Granted from Further Education College

Northampton College

JU/SAW

23 October 2006

Badby Road West
Daventry
Northants NN11 4HJ

Dear Adrienne

This is to confirm that Northampton College will be happy to support you in your research.

Lisa Conopo is the learner support person who can assist you in targeting your survey. Her contact details are:

- phone 01604 736306
- email lisa.conopo@ northamptoncollege.ac.uk

Should you need any further assistance please do not hesitate to contact me.

Yours sincerely

John Underwood
Operations Manager

Northampton College
at Northampton [illegible] Tel: 01604 734 567 [illegible]
at Daventry [illegible] Tel: 01327 300 232 [illegible]

Appendix C: Data Collection Tool

CONFIDENTIAL QUESTIONNAIRE: SEXUAL HEALTH & CONTRACEPTION

Unless otherwise stated please tick one box, representing your answer, for each question.

Sex & Relationship Education

Code

1 Did you receive Sex Education at school?

❑ Yes ❑ No ❑ Don't know — 1 2 3

2 If you answered **yes** to question 1, were your Sex & Relationship Education lessons
(For each set of words tick the box nearest to how you feel)

a	Relevant	❑	❑	❑	❑	❑	Irrelevant — 1 2 3 4 5
b	Interesting	❑	❑	❑	❑	❑	Boring — 1 2 3 4 5

3 Did your school provide information about local sexual health services e.g.Time2Talk?

❑ Yes ❑ No ❑ Don't know — 1 2 3

4 If your school had a School Based Health Service e.g.Time4U, Bodyzone, how often did you use this service for support and information on contraception / sexual health?

❑ No Service ❑ Never ❑ Weekly ❑ Monthly ❑ Termly — 1 2 3 4 5

Sources of Information

5 Thinking about the places that you might have got information about relationships, sexual health issues and contraception how much have you learned from each?

		A lot	Some	Only a little	Nothing at all	
a	**Parents**	❑	❑	❑	❑	1 2 3 4
b	**Brothers / Sisters**	❑	❑	❑	❑	1 2 3 4
c	**Friends**	❑	❑	❑	❑	1 2 3 4
d	**Boyfriends / Partners**	❑	❑	❑	❑	1 2 3 4
e	**Teachers**	❑	❑	❑	❑	1 2 3 4
f	**School Health Nurses**	❑	❑	❑	❑	1 2 3 4
g	**Young Persons Service e.g. Time2Talk**	❑	❑	❑	❑	1 2 3 4
h	**Doctor / Practice Nurse**	❑	❑	❑	❑	1 2 3 4
i	**TV Shows / Movies**	❑	❑	❑	❑	1 2 3 4
j	**The Internet**	❑	❑	❑	❑	1 2 3 4
k	**Magazines**	❑	❑	❑	❑	1 2 3 4
l	**Leaflets**	❑	❑	❑	❑	1 2 3 4

Sexually Transmitted Infections (STI's)

6 How much do you know about Sexually Transmitted Infections like Herpes, Genital Warts and Chlamydia?

❑ Nothing at all ❑ Only a little ❑ A lot — 1 2 3

7 Would you always be aware that you have a Sexually Transmitted Infection?

❑ Yes ❑ No ❑ Don't know — 1 2 3

8 Below are different **opinions** that people have about Sexually Transmitted Infections (STI's), what are **your opinions** on the following statements?

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
a	STI's are not something you have to worry about unless you have sex with a lot of people.	❑	❑	❑	❑	❑	1 2 3 4 5
b	STI's can only be spread when symptoms are present.	❑	❑	❑	❑	❑	1 2 3 4 5
c	I would know if someone I was dating had an STI.	❑	❑	❑	❑	❑	1 2 3 4 5

Chlamydia

9 Have you heard of the Sexually Transmitted Infection called Chlamydia?
❑ Yes ❑ No — 1 2

10 Who is most likely to get Chlamydia? *(Please tick one only)*
❑ Women in their 20's/30's ❑ People under 30 ❑ People in their 30's/40's ❑ Don't know — 1 2 3 4

11 If Chlamydia isn't treated can it cause infertility in women? (i.e. not able to become pregnant)
❑ Yes ❑ No ❑ Don't know — 1 2 3

12 Which of the following are symptoms of Chlamydia? *(Please tick one only)*
❑ A spreading itchy rash over most of the body — 1
❑ Pus-filled lumps around the vagina or penis — 2
❑ Paralysis in a limb — 3
❑ All of the symptoms mentioned — 4
❑ None of the symptoms mentioned — 5
❑ Don't know — 6

13 How is Chlamydia most commonly diagnosed? *(Please tick one only)*
❑ Pelvic examination ❑ Blood test ❑ Urine sample ❑ A swab ❑ Don't know — 1 2 3 4 5

14 Once Chlamydia has been treated, can you get it again?
❑ Yes ❑ No ❑ Don't know — 1 2 3

15 What is the best method of contraception/protection to use to protect yourself from Chlamydia? *(Please specify on the line below)*

_____

Getting Pregnant

16 Can you get pregnant the first time you have sex?
❑ Yes ❑ No ❑ Don't know — 1 2 3

17 Can you get pregnant if you have sex standing up?
❑ Yes ❑ No ❑ Don't know — 1 2 3

18 Does sperm come out of a man's penis before he ejaculates?
❑ Yes ❑ No ❑ Don't know — 1 2 3

19 Can you get pregnant if you have sex during your period?
❑ Yes ❑ No ❑ Don't know — 1 2 3

20 Can you get pregnant if the man withdraws before he ejaculates?
❑ Yes ❑ No ❑ Don't know — 1 2 3

21 If you have sex and think you might be pregnant, is there anything you can do to prevent a pregnancy?
❑ Yes ❑ No ❑ Don't know — 1 2 3

22 Have you heard of emergency contraception, sometimes called the morning after pill?
❑ Yes ❑ No ❑ Don't know — 1 2 3

23 How long after unprotected sex / contraception failure are you able to take emergency contraception (pill) to prevent a pregnancy? *(Please tick one only)*
❑ 12 hours ❑ 24 hours ❑ 48 hours ❑ 72 hours ❑ Don't know — 1 2 3 4 5

Contraception Choices

24 I'd now like your **opinions** about different types of contraception/protection, such as contraceptive pills and condoms.

	Very effective	Somewhat effective	Not too effective	Not effective	Don't know	
a How effective are **oral contraceptive pills** at preventing pregnancy?	❑	❑	❑	❑	❑	1 2 3 4 5
b How effective are **oral contraceptive pills** at preventing Sexually Transmitted Infections?	❑	❑	❑	❑	❑	1 2 3 4 5
c How effective are **condoms** at preventing pregnancy?	❑	❑	❑	❑	❑	1 2 3 4 5
d How effective are **condoms** at preventing Sexually Transmitted Infections?	❑	❑	❑	❑	❑	1 2 3 4 5

25 Tell me how you **feel** about these statements; there are no right or wrong answers.

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
a It would not be that big a deal to have sex without a condom once in a while	❑	❑	❑	❑	❑	1 2 3 4 5
b You only need to use a condom if you have a lot of sexual partners.	❑	❑	❑	❑	❑	1 2 3 4 5
c Buying condoms is embarrassing	❑	❑	❑	❑	❑	1 2 3 4 5
d Sex without a condom isn't worth the risk	❑	❑	❑	❑	❑	1 2 3 4 5

26 Below are a list of **feelings** you might have if someone you were having sexual intercourse with suggested using a condom, how strongly would you agree or disagree with each statement?

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
a Relieved	❑	❑	❑	❑	❑	1 2 3 4 5
b Like the person respected me	❑	❑	❑	❑	❑	1 2 3 4 5
c Insulted	❑	❑	❑	❑	❑	1 2 3 4 5
d Suspicious or worried about the person's past sexual history	❑	❑	❑	❑	❑	1 2 3 4 5
e Like the person was suspicious or worried about my past sexual history	❑	❑	❑	❑	❑	1 2 3 4 5

27 Tell me how you **feel** about the following statements regarding relationships and becoming sexually active.

a Once you have had sex it would be harder to say no the next time
❑ Strongly agree ❑ Agree ❑ Neither agree/disagree ❑ Disagree ❑ Strongly disagree 1 2 3 4 5

b If you have been seeing someone for a while it is expected that you will have sex
❑ Strongly agree ❑ Agree ❑ Neither agree/disagree ❑ Disagree ❑ Strongly disagree 1 2 3 4 5

c There is pressure to have sex by a certain age
❑ Strongly agree ❑ Agree ❑ Neither agree/disagree ❑ Disagree ❑ Strongly disagree 1 2 3 4 5

d Oral sex is not as big a deal as sexual intercourse
❑ Strongly agree ❑ Agree ❑ Neither agree/disagree ❑ Disagree ❑ Strongly disagree 1 2 3 4 5

e Waiting to have sex is a nice idea but nobody really does
❑ Strongly agree ❑ Agree ❑ Neither agree/disagree ❑ Disagree ❑ Strongly disagree 1 2 3 4 5

Sexual Experience(s)

Now for some questions about you. **Remember your answers are confidential.**

28 Please indicate if you have been involved in the following types of sexual activities.

	Yes	No	Not willing to answer	
Touching some one else's genitals	❑	❑	❑	1 2 3
Sexual Intercourse (Penis into vagina)	❑	❑	❑	1 2 3
Oral Sex	❑	❑	❑	1 2 3
Anal Sex	❑	❑	❑	1 2 3

29 Please select the option below which best describes you. *(Sexually active is defined as having sexual intercourse i.e. penis into vagina)*

❑ Heterosexual – not sexually active	❑ Heterosexual – sexually active	1 2
❑ Lesbian – not sexually active	❑ Lesbian – sexually active	3 4
❑ Bisexual – not sexually active	❑ Bisexual - sexually active	5 6

For question 29, if you ticked any of the not-sexually active boxes or the lesbian – sexually active box, please go to question number 57.

For question 29, if you ticked the heterosexual – sexually active or bisexual – sexually active boxes please continue with this questionnaire. I am now interested in your experiences with male partners.

30 What age were you when you **first** had sexual intercourse?

❑ Under 16 ❑ 16 ❑ 17 ❑ 18 ❑ 19 — 1 2 3 4 5

31 How long were you seeing your **first** partner before you had intercourse?

❑ A day	❑ A week	❑ 2 weeks	❑ 3 weeks	1 2 3 4
❑ 1 month	❑ 2 months	❑ 3 months	❑ Over 3 months	5 6 7 8

32 What contraception/method did you use the **first time** you had sexual intercourse?

❑ Withdrawal / pulling out	❑ Condom	❑ Oral Contraceptive Pill	1 2 3
❑ Injectables or Implants	❑ Condom & Oral Contraceptive Pill	❑ Condoms & Injectables/Implants	4 5 6

33 If you didn't use a condom the **first time** you had sexual intercourse, what was your reason? (Please tick as many reasons as apply)

❑ Not aware of a condom	❑ Sex suddenly happened	❑ Condom reduces pleasure	1 2 3
❑ Condom not available	❑ Felt shy to ask	❑ Partner insisted not to use	4 5 6
❑ Didn't know how to use one	❑ Cost	❑ Would interrupt sex	7 8 9
❑ Other contraception used	❑ Other (Please specify) _____		10 11

34 How many partners have you had in the past 12 months?

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more — 1 2 3 4 5 6

35 Thinking about your **current sexual or most recent sexual** relationship, did you talk to your partner about:

		Yes	No	Don't know	
a	Sexually Transmitted Infections	❑	❑	❑	1 2 3
b	Contraception to prevent pregnancy	❑	❑	❑	1 2 3
c	Condoms	❑	❑	❑	1 2 3

36 Have you ever had unprotected sex (not used a condom) because you were drinking?

❑ Yes ❑ No ❑ Don't know — 1 2 3

37 Have you ever worried about STI's or pregnancy because of something you did sexually while drinking?

❑ Yes ❑ No ❑ Don't know — 1 2 3

38 The **first time** you had sexual intercourse had you been drinking?

❑ Yes ❑ No ❑ Don't know 1 2 3

39 The **most recent time** you had sexual intercourse had you been drinking?

❑ Yes ❑ No ❑ Don't know ❑ Not sexually active 1 2 3 4

40 In **general**, when you have sexual intercourse how often do you use contraception and/or protection?

❑ All of the time | ❑ Most of the time | ❑ Some of the time | ❑ Never 1 2 3 4

41 Below is a list of types of contraception/methods or protection. For each one, please tell me if this is a method you have ever use?

		Yes	No	
a	Withdrawal / Pulling out	❑	❑	1 2
b	Condoms on their own	❑	❑	1 2
c	Oral contraceptive pills on their own	❑	❑	1 2
d	Injectables or Implants on their own	❑	❑	1 2
e	Condoms & oral contraceptive pills together	❑	❑	1 2
f	Condoms & injectables/implants together	❑	❑	1 2

42 Have you **ever had** sexual intercourse without a condom? *(Please tick as many as apply)*

❑ Yes ❑ No ❑ Don't know 1 2 3

43 If you have **ever had** sex without a condom, what was your reason?
(Please tick as many reasons that apply)

❑ Didn't know what a condom was	❑ Sex suddenly happened	❑ Condom reduces pleasure	1 2 3
❑ Condom not available	❑ Felt shy to ask	❑ Partner insisted not to use	4 5 6
❑ Didn't know how to use one	❑ Cost	❑ Would interrupt sex	7 8 9
❑ Other contraception used	❑ Other (Please specify) _____		10 11

44 The **last time** you had sexual intercourse did you use a condom?

❑ Yes ❑ No ❑ Don't know 1 2 3

45 If you didn't use a condom the **last time** you had sex, what was your reason? *(Please tick as many reasons that apply)*

❑ Not aware of a condom	❑ Sex suddenly happened	❑ Condom reduces pleasure	1 2 3
❑ Condom not available	❑ Felt shy to ask	❑ Partner insisted not to use	4 5 6
❑ Didn't know how to use one	❑ Cost	❑ Would interrupt sex	7 8 9
❑ Other contraception used	❑ Other _____		10 11

46 When choosing a method of contraception and/or protection how important are each of the statements, listed below, to you?

		Important	Not important	Don't know	
a	How well it prevents pregnancy	❑	❑	❑	1 2 3
b	How well it protects against STI's	❑	❑	❑	1 2 3
c	How much it costs	❑	❑	❑	1 2 3
d	What your partner wants to use	❑	❑	❑	1 2 3
e	That you don't have to discuss it with your partner	❑	❑	❑	1 2 3
f	Availability at the time	❑	❑	❑	1 2 3

47 Have you ever been tested for a Sexually Transmitted Infection?

❑ Yes ❑ No ❑ Don't know 1 2 3

48 If you answered yes to question 47, did you have a Sexually Transmitted Infection

❑ Yes ❑ No ❑ Don't know 1 2 3

49 Have you ever used emergency contraception / the morning after pill?

❑ Yes ❑ No ❑ Don't know 1 2 3

50 Have you ever had a pregnancy test?

❑ Yes ❑ No ❑ Don't know 1 2 3

51 If you answered yes to question 50, were you pregnant?

❑ Yes ❑ No ❑ Don't know 1 2 3

Sexual Health Services

52 Have you ever used a sexual health service e.g. Time2Talk, GP, Family Planning clinic?

❑ Yes, **before** having sex for the first time ❑ Yes, **after** having sex for the first time ❑ No 1 2 3

For question 52, if you ticked **no**, go to question number 57.

53 What type of sexual health service did you use? *(Please tick as many as apply)*

❑ School based health service ❑ Specialist service for young people ❑ Family Planning Service 1 2 3
❑ Doctor ❑ Other (Please specify) _____ 4 5

54 If you visited a sexual health service <u>before</u> you first had sexual intercourse, please state the reason / reasons why. *(Please tick as many as apply)*

❑ To be prepared ❑ Out of curiosity ❑ You planned to have sex soon 1 2 3
❑ To obtain information/advice ❑ Other_____ ❑ Question not applicable 4 5 6

55 If you <u>didn't visit before</u> having sexual intercourse for the first time, please state the reason / reasons why. *(Please tick as many as apply)*

❑ You didn't plan or expect to have sex ❑ You got condoms from another source 1 2
❑ You were worried about confidentiality ❑ You didn't think about it 3 4
❑ You were worried about your age ❑ You didn't know of any services 5 6
❑ Embarrassment ❑ It would have been difficult to get there 7 8
❑ Other (Please Specify)_____ ❑ Question not applicable 9 10

56 If you visited a sexual health service <u>after</u> you first had sexual intercourse, please state your reason / reasons for visiting *(Please tick as many as apply)*

❑ To be prepared for the next time ❑ To be prepared for sex with a new partner 1 2
❑ To get condoms ❑ To discuss and switch method of contraception 3 4
❑ You had unprotected sex ❑ Worried about sexually transmitted infections 5 6
❑ Worried about pregnancy ❑ Contraceptive failure 7 8
❑ Pregnancy test ❑ Emergency contraception 9 10
❑ Other (Please specify) _____ ❑ Question not applicable 11 12

PERSONAL INFORMATION

57 What age are you?

❑ 16 ❑ 17 ❑ 18 ❑ 19 1 2 3 4

58 How would you describe your ethnic origin?

❑ Asian or Asian British ❑ Black or Black British ❑ Mixed 1 2 3
❑ White ❑ European ❑ Other Ethnic Group 4 5 6
❑ I do not wish to disclose 7

Thank you for taking the time to complete this questionnaire.

Remember, if you have any questions or concerns regarding your own sexual health you can contact Time2Talk for information, advice and support.

Time2Talk, The Abbey, Market Square, Daventry
Tel: 01327 706706. info@time2talk.org.uk

Please return your completed questionnaire to:
Adrienne Hand, Public Health Department, Northamptonshire PCT, Nene House, Sopwith Way, Daventry, NN11 5EA

Appendix D: Participant Information Sheet

Can you help?
Are you female aged 16 to 19?

If the answer is yes, your help is needed to complete a
confidential questionnaire about sexual health and contraception.

Responses are welcomed from both sexually active & non-sexually active young women.
Your anonymity and confidentiality will be maintained at all times.

Who am I?
I am an employee of the Northamptonshire NHS Primary Care Trust and a student at Bedfordshire University. As part of my studies in Public Health I have to carry out research and as I have both a professional and personal interest in young peoples' health I have chosen to do research in this area.

Why am I doing this research?
There are many ways in which young women access information, advice and support regarding sexual health and contraception. My research is designed to identify what knowledge young women have about sexual health and contraception and how this knowledge is put into practice regarding their own sexual health and contraceptive choices.

What will happen to the information provided on the questionnaire?
Once you have completed and returned the questionnaire the information you provide will be entered on to a computer and a programme will be used to analyse the data. All this information will be kept confidential. It will not be possible to know, at any stage, who has provided the information. Your anonymity and confidentiality will be protected at all times.

What happens next?
Once all of the information provided on the questionnaires has been analysed I will produce a report that will make recommendations to those organisations that provide sexual health services to young people in your age group. It may also result in developing work with young people about the information, advice and support that is offered to them regarding sexual health and contraception.

Still happy to go ahead? Excellent!
What do you need to do next?

Please complete the questionnaire in the following way:
- By yourself
- Without looking up the answers (it is important for me to understand your current levels of knowledge)

Once your questionnaire is complete, please return it in the envelope provided within 7 days.

Got something you would like to ask me about my research?
I can be contacted at the following address:
Adrienne Hand, Public Health Department, Northamptonshire Primary Care Trust,

Want to talk to somebody about sexual health and/or contraception?
If after completing this questionnaire you have any questions or concerns regarding your own sexual health, Time2Talk are aware that I am conducting this research and will be more than happy to hear from you.

Time2Talk, T

Participation in this research is voluntary and you are free to withdraw at anytime.
However, please note that by returning your completed questionnaire you are giving consent for the information you have provided to be used, analysed and presented as research findings.

Appendix E: E-mail - Seeking clarity regarding NHS Ethics Committee approval

-----Original Message-----
From: McKie Jeannie
Sent: 16 February 2006 10:03
To: 'Adrienne.Jarret'
Subject: FW: FW: Ethics Committee Approval - Query

Dear Adrienne,

Please see Dr Edwards Comments below. If you would like written confirmation of this please let me know your postal address.

Kind Regards

Jeannie McKie
Administrative Officer
Nottingham Research Ethics Committee
Tel: 0115 9123344 x 49428
Fax: 0115 9123300

-----Original Message-----
From: Carl Edwards
Sent: 15 February 2006 06:36
To:
Subject: RE: FW: Ethics Committee Approval - Query

Hi Jeannie,

looks like it's not one for the REC. The only comment I have is that I think that under 18s are regarded as minors for the purposes of various child protection regulation and that she should check that it's alright to do it withut parental consent? all the best,

Carl

Dr. Carl M. Edwards
0774 701 3668
carledwards101@hotmail.com

From: McKie Jeannie
To:e"
Subject: FW: Ethics Committee Approval - Query
Date: Mon, 13 Feb 2006 16:15:25 -0000

Dear Carl,

Could you take a quick look at the query below. As they aren't recruiting through the NHS I don't think it would need to come through a REC, what do you think?

Kind Regards
Jeannie McKie
Administrative Officer
Nottingham Research Ethics Committee
Tel: 0115 9123344 x 49428
----Original Message-----

From: Adrienne Jarrett [
Sent: 13 February 2006 15:51
To:
Subject: Ethics Committee Approval - Query

Hello Jeannie, further to our telephone conversation please find below details of the research that I propose to undertake.

I am currently studying for my Masters in Public Health at Luton University. This is a one year course and following submission of my proposal next week, and I hope its subsequent approval, I will then need to move forward with my plans to have my research and dissertation complete by the end of Sept 2006.

I would be grateful if you could find out for me if I would need ethics committee approval for the research detailed below.

I intend to survey, via self-completed questionnaires, a sample of 16-19 year women in the Daventry area of Northamptonshire. These surveys may be followed up with a focus group to validate the findings of the surveys - the members of this focus group would not be the same young women that have completed a questionnaire, therefore the questionnaires will be anonymous and there will be no individual follow up required.

I intend to access these young women via the local further education college, youth clubs and a local young persons advice and support service. By identify young women over the age of 16 I anticipate that I will not need parental consent, only the consent of the organisation that they are attending to conduct the research

I would like to survey the young women to find out about their knowledge and attitudes to sexually transmitted infections, contraception and unwanted pregnancy and see how this relates to their sexual behaviour and choice of contraception. I will be asking both sexually and non-sexually active young woman to complete the questionnaire, therefore they will not need to make any personal disclosure to me about their sexual activity in order to participate. This info would only be disclosed in the questionnaire which as I have already stated will remain anonymous.

I would not be using NHS records to identify my sample, I would be going out to find them in their settings and NHS staff will not be involved in this research either, apart from raising their awareness that I was undertaking the research.

I look forward to hearing from you in due course, thank you for your help.

Adrienne Jarrett
Public Health Manager

Daventry & South Northants Primary Care Trust

Appendix F: Letter - Approval from NHS Ethics Committee to conduct research

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1
1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 9123344 Ext 49435
Facsimile: 0115 9123300

20th February 2006

Adrienne Jarrett

Dear Ms Jarrett

Full title of project: Masters in Public Health at Luton University, research dissertation.

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

- Email dated 13th February 2006
  Outline of proposed dissertation research

These documents have been considered by the Chair, who has advised that the project is not one that is required to be ethically reviewed under the terms of the Governance Arrangements for Research Ethics Committees in the UK.

The Chair agreed that this project would not need approval from an NHS Research Ethics Committee. The only comment he had was that for purposes of consent under 18's are regarded as minors and suggested that you should check if parental consent would be required.

Although review by a Research Ethics Committee is not required, you should check with the R&D Department for Daventry and South Northants PCT whether management approval is required before the project starts.

Yours sincerely

Ms Linda Ellis
Committee Co-ordinator

E-mail: linda.ellis@rushcliffe-pct.nhs.uk

Appendix G: Application Form – NHS Research and Development

NHS Research and Development

APPLICATION FORM

Research management and governance approval is separate from ethics approval. This form should be completed by the Principal Investigator, after reading the Guidance Notes on this website and any guidance or instructions from the NHS organisation where the research will take place. See the Glossary for clarification of terms used in this form.

1a. Short title of research. Young Women, Contraception and Sexual Health

1b. Full title of research. Contraception and Sexual Health: What knowledge do 16–19 year old young women have about contraception and sexual health and how does this relate to practice?

1c. Name of Chief Investigator for this study. Mrs Adrienne W Hand

2a. Name of the NHS organisation within which the research will take place.
This research will not take place within an NHS Organisation. As an NHS employee, undertaking a Masters Degree in Public Health at the University of Bedfordshire, I am completing the research for my Dissertation. The research will be conducted at Further Education establishment, with their approval.

2b. Is this organisation a Primary Care Organisation? N/A

2c. Specify the location(s)/ department(s) within the NHS organisation where the research will take place.
N/A - The research will be conducted at a Further Education establishment with their approval.

3. Proposed local start and end date of research within the NHS organisation.
Start Date: 13/11/2006 Duration (Months): 1 End Date: 13/12/2006

4a. Name of Principal Investigator/ Local Collaborator for this study at this site.
Name: Mrs Adrienne W Hand
Employing organisation: Northamptonshire Primary Care Trust
Post: Healthy Schools Programme Manager (previously Acting Public Health Manager – 18 months)
Qualifications: Certificate in Health Promotion, Postgraduate Diploma in Public Health
Address:
E-mail:

4b. Will this person interact with the staff of the NHS organisation, or research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care? No

5. Other members of the research team N/A

5a. Name. N/A

5b. Will this person interact with the staff of the NHS organisation, or research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care? No

The above section must include all staff described in COREC Form C3 i iii. If any more staff were listed in COREC Form C18 or on an attached sheet, they should be included on this form. Please also provide details for any other members of the local study team not listed in COREC form C3 who will interact with the staff of the NHS organisation, or research participants, their organs, tissue or data in a way that has direct bearing on the quality of care.

6. Student Research

6a. Does the research have the primary aim of being educational? Yes

6d. Name and contact details of clinical supervisor in NHS organisation (where required). N/A

7. Is this research sponsored by a commercial company? No

8. How much external funding will be provided locally for the research? None

9. Which organisation will receive and manage this funding? N/A

10. How many research participants/ samples is it anticipated will be recruited/ obtained from this organisation in total?
60-100 students at the Further Educational establishment.

11. How much additional time above routine care or duties will members of the local research team spend on this research in the NHS organisation? This may include, for example, time obtaining consent, interviewing patients, entering data, or analysing data. Many NHS organisations will require information on the type of activity, the additional time spent on this activity, and the duration of this activity over the course of the research. N/A

12. List all supplies or equipment in the NHS organisation, additional to that required for routine care, that will need to be purchased for this research by the NHS, e.g. computer, centrifuges, sample tubes. List all other additional expenses that will be incurred by the NHS organisation as a consequence of the research, e.g. travel, postage. Where information has been provided about service support and/or excess treatment costs, this should be listed here. N/A

13. List all other staff/ services/ departments/ divisions/ units/ groups within the NHS organisation that will incur work additional to routine practice as a consequence of the research. This includes tests/ procedures/ services by support departments, and any patient care additional to routine care, e.g. extra visits, operating theatre time, bed stays. Where information has been provided about service support and/or excess treatment costs, this should be listed here. N/A

This section deals with authorisation by managers within the NHS organisation. It should be signed in accordance with the guidance provided by the NHS organisation. This may include authorisation by line managers, service managers, support department managers, pharmacy, data protection officers or finance managers. Those completing this section should confirm in the text what the authorisation means, in accordance with the guidance provided by the NHS organisation.

*1.*Type of Authorisation: Authorisation to complete the research in personal capacity whilst giving recognition to role within and employment by the Northamptonshire PCT
Signature: Signed: Carole Dehghani.....

Mrs Carole Dehghani. Assistant Director of Public Health

Declaration by the Principal Investigator
The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

1. I undertake to abide by the principles of the Research Governance Framework and, if relevant, the Medicines for Human Use (Clinical Trials) Regulations 2004.
2. I undertake to conduct this research in accordance with the relevant Good Clinical Practice guidelines.
3. I take responsibility for ensuring that all staff involved in this research hold appropriate contracts of employment for the duration of the research, and are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines.
4. If the research is approved, I undertake to adhere to the study protocol, and to request approval from the NHS organisation within local timelines for any subsequent amendments to the protocol.
5. I undertake not to conduct any research that does not comply with any conditions requested by the NHS organisation.
6. I undertake to complete any interim and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct this research within the NHS organisation is dependent on satisfactory completion of such reports.
7. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
8. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
9. I understand and agree that study files and documents and research records and data may be subjected to inspection by the NHS organisation, the sponsor or an independent body for audit and monitoring purposes.
10. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take
11. responsibility for ensuring that all staff involved in this research are aware of their responsibilities to disclose conflicts of interest.
12. I understand that information relating to this research, and about me as a researcher, will be held by the R&D Manager and on the R&D database. This information will be managed according to the principles established in the Data Protection Act 1998.

Signature: Adrienne W Hand

Appendix H: Letter - Approval from NHS Research and Development

29 NOV 2006

NHS

Leicestershire, Northamptonshire and Rutland
Primary Care Research Alliance

Third Floor
Enderby House
92 Regent Road
Leicester
LE1 7PE

Telephone: 0116 295 4080
Fax: 0116 295 4177
Email: info@lnrpcra.nhs.uk
www.lnrpcra.nhs.uk

27/11/06

LNR PCRA - REF 0635 (Please quote this reference on all correspondence)

Dear Mrs Hand

Contraception: What choices do 16 – 19 year old young women make and why? A Survey

We are pleased to advise you that, under the authority delegated to us as the designated RM&G PCT (hosted by Leicester City PCT) for the three PCTs in Leicestershire, Northamptonshire and Rutland, PCT approval for the above research project is now in place. We therefore advise that approval from the Leicestershire, Northamptonshire and Rutland Primary Care Research Alliance to carry out your study within STATE PCTs is now granted.

It is required, under the terms of the Research Governance Framework, that all researchers undertaking work within an NHS organisation which impacts upon patient care must have an NHS contract for the term of the research study. ***Therefore The Leicestershire Northamptonshire and Rutland Primary Care Research Alliance (LNR PCRA) will require study researchers to hold an honorary contract with the LNR PCRA in order for the study to take place in the Leicestershire, Northamptonshire and Rutland primary care sector.*** It is the responsibility of the Chief Investigator to ensure that all study staff have a valid contract in place with the LNR PCRA before they start work within the Primary Care Trusts of Leicestershire, Northamptonshire and Rutland. Please note that this applies when there is ***any*** change in the research staff working in the primary care sector for the duration of the study. Requests for honorary contracts need to be made to the LNR PCRA office, address as above.

Could you please ensure that any interim or final reports, protocol amendments or any documents that require submission to a REC are channelled through this office. In addition can any adverse event relating to this study be reported to us, please. We will undertake to forward any documentation to the REC as well as advise the relevant PCT/s in accordance with Research Governance requirements.

Please also be aware that, where required under NHS obligations, we will submit details of this study to the National Research Register to log PCT involvement in this study. The Alliance is also currently implementing new systems for research governance on behalf of local PCTs, so the study may be subject to some follow up and/or auditing during its field work stage.

May I take this opportunity to wish you the very best of luck with this study.

Yours sincerely

Sue Palmer-Hill
Research & Development Manager

Appendix I: Tutor Information Sheet

Dear Tutor,

CONFIDENTIAL STUDENT QUESTIONNAIRE - Sexual Health & Contraception

Please find together with this information sheet questionnaires to be given out to your female students aged 16 to 19 years. Northampton College (Daventry) has given permission for the questionnaire to be distributed.

Who am I?
I am an employee of the Northamptonshire NHS Primary Care Trust and a student at Bedfordshire University. As part of my studies in Public Health I have to carry out research and as I have both a professional and personal interest in young peoples' health I have chosen to do research in this area.

Why am I doing this research?
There are many ways in which young women access information, advice and support regarding sexual health and contraception. My research is designed to identify what knowledge young women have about sexual health and contraception and how this knowledge is put into practice regarding their own sexual health and contraceptive choices.

What will happen to the information provided?
Once the questionnaires are completed and returned the information provided will be entered on to a computer and be analysed. All the information will be kept confidential. It will not be possible to know, at any stage, who has provided the information. I will then produce a report that will make recommendations to those organisations that provide sexual health services to young people.

I would be grateful if you would encourage your students to complete a questionnaire and return it in the envelope provided within 7 days.

In order to gain maximum benefit from the results I need as many questionnaires completed and returned as possible.

If you would like any further details regarding my research I can be contacted at the following address: Adrienne Hand,

If any of your students want to talk to somebody about sexual health and/or contraception, Time2Talk are aware that I am conducting this research and will be more than happy to hear from them.

Time2Talk,

Participation in this research by your students is voluntary and they are free to withdraw at anytime. However, by returning a completed questionnaire they are giving consent for the information they have provided to be used, analysed and presented as research findings.

Thank you for your help.

Appendix J: Letter – Seeking approval from DSN Primary Care Trust

7th April 2006

Kevin Herbert, CEO
Daventry & South Northants PCT
Nene House
Sopwith Way
Daventry
NN11 5EA

Dear Kevin

Re: MSc Public Health – Research / Dissertation

I am currently studying for my Masters in Public Health at Luton University and in order to complete my programme I am required to undertake research that I can write up as my dissertation.

Having submitted my research proposal to Luton University for approval I have recently received confirmation that they are happy with me to proceed and conduct my research.

Although I will be conducting my research and writing my dissertation in a personal capacity I am keen that the PCT are fully aware of my research and the approach that I plan to take. I would also like to be able to declare to those that will be involved in the research that I am an employee of the PCT working as the Acting Public Health Manager.

I envisage that the research findings will be of interest to the PCT and I would therefore anticipate that I would like to make them available to support any future development of Young Peoples Sexual Health Services both locally and across the County.

> ***The Research Abstract:***
> *This research will generate local baseline information about the methods of contraception that 16 - 19 year old young women use, or don't use, and the rationale for their choices. Utilising survey methodology all 16-19 year old young women attending the local Further Education College will be invited to complete an anonymous and confidential questionnaire. The questionnaire will be designed and piloted by young people known to the local Young Persons Sexual Health Service. Following the collection*

of quantitative data, if required, focus groups and in-depth interviews will be held to consolidate the results. In essence this research will establish what knowledge young women have about preventing pregnancy and Sexually Transmitted Infections (STI's) and determine how and why they put, or don't put, this knowledge into practice.

For your information I have contacted the Local Research Ethics Committee and they have confirmed, in writing, that it will not be necessary for me to gain ethics Committee approval in order to conduct the research.

I would be grateful if you would consider granting me the ability to proceed with the research and allow me to declare my position within the PCT to those involved. If you have no objections to this I will then be in a position to write to the other parties that I wish to involve in my research.

If you require any further information please do not hesitate to contact me. I look forward to hearing from you in the near future.

Yours sincerely

Adrienne Jarrett

Appendix K: Letter – Seeking approval ˜ om PCT Line Manager

7th April 2006

Carole Dehghani, Acting Director of Public Health
Daventry & South Northants PCT
Nene House
Sopwith Way
Daventry
NN11 5EA

Dear Carole

Re: MSc Public Health – Research / Dissertation

As you are aware I am currently studying for my Masters in Public Health at Luton University. In order to complete my programme I am required to undertake research that I can write up as my dissertation.

Having submitted my research proposal to Luton University for approval I have recently received confirmation that they are happy with me to proceed and conduct my research.

Although I will be conducting my research and writing my dissertation in a personal capacity I am keen that the PCT are fully aware of my research and the approach that I plan to take. I would also like to be able to declare to those that will be involved in the research that I am an employee of the PCT working as the Acting Public Health Manager.

I envisage that the research findings will be of interest to the PCT and I would therefore anticipate that I would like to make them available to support any future development of Young Peoples Sexual Health Services both locally and across the County.

> ***The Research Abstract:***
> *This research will generate local baseline information about the methods of contraception that 16 - 19 year old young women use, or don't use, and the rationale for their choices. Utilising survey methodology all 16-19 year old young women attending the local Further Education College will be invited to complete an anonymous and confidential questionnaire. The questionnaire will be designed and piloted by young people known to the local Young Persons Sexual Health Service. Following the collection*

of quantitative data, if required, focus groups and in-depth interviews will be held to consolidate the results. In essence this research will establish what knowledge young women have about preventing pregnancy and Sexually Transmitted Infections (STI's) and determine how and why they put, or don't put, this knowledge into practice.

For your information I have contacted the Local Research Ethics Committee and they have confirmed, in writing, that it will not be necessary for me to gain ethics Committee approval in order to conduct the research.

I would be grateful if you would consider granting me the ability to proceed with the research and allow me to declare my position within the PCT to those involved. If you have no objections to this I will then be in a position to write to the other parties that I wish to involve in my research. I have also written to Kevin Herbert, CEO, seeking his permission to proceed with my research.

If you require any further information please do not hesitate to contact me. I look forward to hearing from you in the near future.

Yours sincerely

Adrienne Jarrett

Appendix L: Letter – Approval Granted from DSN Primary Care Trust

Daventry and South Northants NHS
Primary Care Trust

Ref: S/Drive/CEO/letters2006/060310 AJ

10 April 2006

Trust HQ
Nene House
Drayton Way
Drayton Fields Industrial Estate
Daventry
NN11 5EA

Tel: 01327 705610
Fax: 01327 877058

Direct Dial: 01327 708101
Direct Fax. 01327 703250

Dear Adrienne

MSc Public Health – Research / Dissertation

Thank you for your letter of 7 April regarding your research in connection with your MSc in Public Health.

It is important that the PCT is aware of the research. I am assuming that the research is to be undertaken in your own time?

In principle I am happy that you proceed with the research, and to declare your position as Acting Public Health Manager for this PCT. It is important that the position does not influence the decision of any party to participate in the research. It must be made clear that the research is being undertaken in a private capacity, and not on behalf of the PCT.

To that end, I think it would be helpful if we could agree the form of words to be used in any written or verbal approach to prospective participants in the project.

Regards.

Yours sincerely

KEVIN HEGBERT
CHIEF EXECUTIVE

Appendix M: Letter – Approval Granted from PCT Line Manager

Daventry and South Northants NHS
Primary Care Trust

Trust HQ
Nene House
Drayton Way
Drayton Fields Industrial Estate
Daventry
NN11 5EA

Tel: 01327 705610
Fax: 01327 877058

Ref: s/dph/dph/letters/

Date 29 August 2006

Direct Dial: 01327 708112
Direct Fax: 01327 706510
Carole.dehghani@dsnpct.nhs.uk

Dear Adrienne

Re: MSc Public Health – Research/Dissetation

Thank you for your letter dated 7 April 2006 regarding the research needed to complete your dissertation. I am happy for you to proceed with the research as stated within your letter in your personal capacity whilst recognising your role within the PCT.

If I can be of any further assistance please do not hesitate to ask.

Best wishes

CAROLE DEHGHANI
Acting Director of Public Health

Appendix N: Letter – Seeking approval from Time2Talk

16th October 2006

Andy Nixon
Manager
Time2Talk

Dear Andy

Re: MSc Public Health – Research / Dissertation

I am studying for my Masters in Public Health at The University of Bedfordshire and in order to complete my Masters Degree I am required to undertake research that I can write up as my dissertation.

Having submitted my research proposal to the university for approval I have received confirmation that they are happy for me to proceed and conduct my research.

Although I will be conducting my research and writing my dissertation in a personal capacity I have been granted permission from Kevin Herbert and Carole Dehghani from the former Daventry & South Northants Primary Care Trust to conduct the research. As you will be aware I am an employee of the PCT and have worked as the Acting Public Health Manager. Since the formation of the new Northamptonshire PCT I have returned to my substantive post of Healthy Schools Programme Manger.

I anticipate that the research findings will be of interest to both Time2Talk and the PCT and I would therefore anticipate that I would like to make the findings available to support any future development of Young Peoples' Sexual Health Services both locally and across the County.

> ***The Research Abstract:***
> *This research will generate local baseline information about the methods of contraception that 16 - 19 year old young women use, or don't use, and the rationale for their choices. Utilising survey methodology all 16-19 year old young women attending the local Further Education College will be invited to complete an anonymous and confidential questionnaire. The questionnaire will be designed and piloted by young people known to the local Young Persons Sexual Health Service. Following the collection of quantitative data, if required, focus groups and in-depth interviews will be held to consolidate the results. In essence this*

research will establish what knowledge young women have about preventing pregnancy and Sexually Transmitted Infections (STI's) and determine how and why they put, or don't put, this knowledge into practice.

For your information I have contacted the Local Research Ethics Committee and they have confirmed, in writing, that it will not be necessary for me to gain ethics Committee approval in order to conduct the research.

I would be grateful if Time2Talk would consider working in partnership with me to finalise the development of a questionnaire that will enable me to collect relevant data from young women at the Local Further Education College. Ideally I would like to work with a group of your service users and ask for their input in finalising and piloting the questionnaire. If you feel that this is something that you would be able to accommodate, over the next couple of months, then obviously we could then discuss the most appropriate way to engage and identify your service users.

If you require any further information please do not hesitate to contact me. I look forward to hearing from you in the near future.

Yours sincerely

Adrienne Hand

Appendix O: E-mail – Approval Granted from Time2Talk

-----Original Message-----
From: Andy Nixor.
Sent: 26 October 2006 16:01
To: 'Adrienne Hand'
Subject: RE: Your request re research dissertation

Hi Adrienne

Sorry for taking so long to get back about your request. Happy to help anyway we can, have spoken to Julie and she is probably the best one to liaise with. Northampton College Daventry only has about 350 students in total so maybe Julie could use Moulton student?

Hope all is well

Speak soon

Andy

Appendix P: Projected Research Budget

Description	Detail	Total
Researcher: Develop research, collect results, prepare results & disseminate	Public Health Manager @ £125 + 16% on-costs= £145 p/day 2 days p/w for 34 weeks: Mar – Oct 2006	£9,860
Statistician: Sample size calculation, define statistical analysis to undertake & support final data analysis	Statistician@ £150 + 16% on-costs= £174 p/day 4 days p/m for 6 months: March – Aug 2006	£4,176
Data Analyst: Support development of research tool, input and analyse results.	Data Analyst @ £95 + 16% on-costs = £110 p/day 2 days p/w for 15 weeks: May – July 2006	£3,300
Admin Support:	To support whole project as required £10 p/h + 16% on-costs= £11.60 p/h 10 hours p/w for 34 weeks	£3,944
Hospitality	For young people at Time2Talk when consulting on data collection tool and piloting questionnaire	£50
Computer & Printer		£850
Stationery		£150
Telephone		£150
Postage	Minimal postage prior to dissemination of results – questionnaires will be collected on site to help with response rate.	£180
Printing Executive Summary		£200
Leaflet / Flyer	Design & Print costs for appropriate young persons leaflet / flyer	£650
Travel	Up to 200 miles per month @53p per mile between Researcher, Data Analyst and Statistician.	£848
Seminar	Venue Hire & Hospitality for up to 50 people	£500
	TOTAL	**£24,778**

Appendix Q: Research Timetable – From original research proposal

Description	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Finalise & Submit Research Proposal									
Confirm Ethics Committee decision, i.e. not to submit an application									
Approach Gatekeepers: DPH & CEO of DSN PCT, College & Time2Talk									
Approach University of Northampton regarding Data Analysis									
Design Participant Information Form									
Clarify Statistical requirements for project, i.e. no. of responses required and tests to be conducted on data									
Design Data Collection Tool									
Pilot Data Collection Tool – Test for reliability & validity									
Inform stakeholders that research is being undertaken in preparation for a rise in young people accessing services									
Collect Data at College									
Preliminary Data Analysis									
Conduct Focus Group / in-depth interviews if necessary									
1st Draft of research completed to date submitted to supervisor									
Full Data Analysis									
2nd Draft of Research submitted to supervisor									
Develop Executive Summary & Presentation									
Submit Final Research Findings – Dissertation									
Disseminate Findings									
Description	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**

Appendix R: Research Timetable – Actual

Description	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Finalise & Submit Research Proposal												
Confirm Ethics Committee decision, i.e. not to submit a full application												
Approach Gatekeepers: DPH & CEO, DSN PCT College, Time2Talk												
Approach University of Northampton regarding Data Analysis												
Design Participant Information Form												
Clarify Statistical requirements for research, i.e. no. of responses / tests												
Design Data Collection Tool												
Pilot Data Collection Tool												
Inform stakeholders that research is being undertaken / query rise in young people accessing services												
Collect Data												
Data Analysis												
1st Draft of research completed to date submitted to supervisor												
Full Data Analysis												
2nd Draft of Research submitted to supervisor												
Submit Final Research Findings – Dissertation												
Develop Executive Summary & Presentation												
Disseminate Findings												
Description	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**

Appendix S: Extract of Coding Frame Worksheet

No.	Q. 1	Q. 2a	Q. 2b	Q. 3	Q. 4	Q. 5a	Q. 5b	Q. 5c	Q. 5d	Q. 5e	Q. 5f	Q. 5g	Q. 5h	Q. 5i	Q. 5j	Q. 5k	Q. 5l	Q. 6	Q. 7	Q. 8a	Q. 8b	Q. 8c	Q. 9	Q. 10
1	2	n/a	n/a	1	3	1	4	1	3	2	2	2	1	3	3	4	2	2	2	4	4	4	1	1
2	2	n/a	n/a	2	0	3	4	2	1	3	4	4	4	2	4	1	3	3	2	5	5	5	1	1
3	1	0	5	1	2	4	4	4	1	4	4	4	4	4	4	4	4	1	2	4	4	4	1	4
4	1	5	0	2	5	2	1	1	2	3	4	2	3	3	4	4	4	2	2	5	5	5	1	2
5	1	1	1	1	2	3	4	1	2	2	3	1	3	1	1	2	1	3	2	5	5	5	1	1
6	1	2	3	3	1	2	1	1	2	4	3	3	1	2	4	2	2	2	2	1	1	1	1	4
7	1	4	4	1	1	4	4	3	3	4	4	4	4	4	4	4	4	2	1	3	3	3	1	4
8	1	4	5	1	2	4	4	2	2	4	4	4	2	4	4	3	3	2	2	4	4	4	1	4
9	1	3	5	1	2	2	4	3	4	2	4	4	3	3	4	3	4	2	2	4	5	4	1	4
10	1	3	5	2	2	2	3	2	3	2	4	4	3	3	4	2	2	3	2	5	5	5	1	1
11	2	n/a	n/a	1	2	1	4	1	4	4	4	1	4	4	4	4	1	2	2	5	5	5	1	4
12	1	3	4	1	1	1	3	2	2	4	4	1	1	3	4	2	2	2	1	4	5	4	1	2
13	1	2	1	1	5	2	4	2	1	2	1	1	1	1	3	1	2	2	2	3	2	3	1	1
14	1	3	1	2	1	1	4	2	4	1	2	3	4	2	4	4	2	3	1	5	4	4	1	4
15	1	1	2	1	2	2	4	2	4	2	2	2	2	3	3	2	2	2	3	2	2	4	1	2
16	1	2	3	1	2	4	4	2	4	4	4	4	4	4	4	4	2	2	2	4	4	5	1	1
17	1	5	4	1	3	4	4	4	4	4	4	4	4	4	4	1	4	2	2	4	4	5	1	4
18	1	3	3		3	2	1	1	1	3	3	4	2	1	3	1	3	3	2	5	5	5	1	1
19	1	1	1	1	2	2	4	3	3	3	4	3	4	2	4	3	4	2	2	4	4	4	1	2
20	1	1	3	1	2	2	1	2	2	2	2	1	2	3	4	2	3	3	2	5	5	4	1	2
21	1	0	1	3	1	1	2	4	2	1	1	1	2	2	2	1	1	2	1	4	4	4	1	4
22	1	1	1	1	2	1	4	2	2	2	4	3	4	4	4	4	4	3	1	5	3	5	1	1
23	1	2	2	1	2	2	4	2	2	4	4	3	4	3	3	3	4	2	1	4	4	4	1	1
24	2	n/a	n/a	1	2	1	3	2	4	4	3	3	2	4	2	3	3	2	1	5	4	5	1	4
25	2	n/a	n/a	1	2	2	4	1	2	4	4	4	4	2	4	1	3	2	3	4	2	4	1	1
26	1	1	1	1	4	4	4	1	1	4	3	1	3	1	1	1	1	3	1	2	3	2	1	1
27	1	0	2	2	5	2	4	1	2	2	2	3	2	2	4	3	3	2	2	3	4	5	1	1
28	1	3	3	1	2	1	2	1	1	3	3	1	1	2	2	2	2	3	1	4	5	4	1	1
29	1	3	3	1	5	4	3	3	3	2	3	3	4	2	2	2	2	2	3	2	2	2	1	4
30	1	1	5	1	2	3	4	1	2	3	4	4	2	1	4	2	3	3	2	5	4	4	1	2
31	1	0	5	1	1	1	3	1	2	3	2	2	2	1	1	1	2	3	2	5	5	5	1	1
32	1	1	2	1	1	1	2	3	3	3	2	4	3	3	4	3	3	2	2	5	5	5	1	1
33	1	4	4	1	4	1	4	1	2	2	2	3	1	2	2	2	2	2	2	5	5	5	1	1
34	1	2	1	1	1	4	3	2	3	2	2	4	4	1	1	1	1	2	3	3	2	1	1	1
35	1	1	2	3	2	3	4	1	1	2	2	2	3	2	2	2	2	2	2	4	4	4	1	1
36	1	2	1	1	2	1	4	4	2	3	2	4	4	3	4	4	4	3	2	2	5	3	1	1
37	1	0	5	1	3	1	4	2	2	2	2	2	4	4	4	4	4	3	1	4	4	4	1	1
38	1	0	4	1	3	1	4	1	2	2	2	3	3	3	4	3	3	3	1	4	4	4	1	4
39	1	0	3	3	2	2	4	2	3	4	4	4	4	3	4	4	4	2	2	4	4	4	1	1
40	1	0	5	1	2	4	4	3	2	4	3	3	4	4	4	3	4	2	1	5	4	4	1	4

Appendix T: Results recorded by Sexually Active & Non-Sexually Active Young Women

Total Number of Responses (*n*) = 58 (100%)

Number of Responses from Sexually Active Young Women = 46 (79%) – shown on orange	
Number of Responses from Non Sexually Active Young Women = 12 (21%) – shown in blue	
N/A = Not Applicable	0 = No Response / Missing Data

Sex & Relationship Education

1 Did you receive Sex Education at school?

Yes 40 1t1 No 6 1 Don't know 0 0

2 If you answered **yes** to question 1, were your Sex & Relationship Education lessons

a	Relevant	0 7 3	1 10 1	2 6 4	3 10 3	4 3 0	5 4 0	N/A 6 1	Irrelevant
b	Interesting	0 1 0	1 9 1	2 5 4	3 11 3	4 7 3	5 7 0	N/A 6 1	Boring

3 Did your school provide information about local sexual health services e.g.Time2Talk?

Yes 36 8 No 5 3 Don't know 5 1

4 If your school had a School Based Health Service e.g.Time4U, Bodyzone, how often did you use this service for support and information on contraception / sexual health?

0 2 0 No Service 8 2 Never 22 10 Weekly 7 0 Monthly 3 0 Termly 4 0

Sources of Information

5 Thinking about the places that you might have got information about relationships, sexual health issues and contraception how much have you learned from each?

		A lot		Some		Only a little		Nothing at all	
a	Parents	14	3	17	5	7	2	8	2
b	Brothers / Sisters	7	1	4	1	6	2	29	8
c	Friends	16	3	20	4	7	4	3	1
d	Boyfriends / Partners	8	0	23	4	10	2	5	6
e	Teachers	2	4	18	3	13	1	13	4
f	School Health Nurses	6	1	12	2	7	2	21	7
g	Young Persons Service	8	1	6	2	13	2	19	7
h	Doctor/ Practice Nurse	8	0	8	4	10	1	20	7
i	TV Shows / Movies	9	2	16	4	13	3	8	3
j	The Internet	4	1	5	2	7	1	30	8
k	Magazines	8	2	15	3	10	6	13	1
l	Leaflets	6	1	13	4	13	3	14	4

Sexually Transmitted Infections (STI's)

6 How much do you know about STI's like Herpes, Genital Warts & Chlamydia?

Nothing at all 2 0 Only a little 23 9 A lot 21 3

7 Would you always be aware that you have a Sexually Transmitted Infection?

Yes 12 4 No 26 6 Don't know 8 2

8 Below are different **opinions** that people have about Sexually Transmitted Infections (STI's), what are **your opinions** on the following statements?

		Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree	
a	STI's are not something you have to worry about unless you have sex with a lot of people.	2	0	6	1	5	0	18	3	15	8
b	STI's can only be spread when symptoms are present.	1	0	5	1	6	0	17	6	17	5
c	I would know if someone I was dating had an STI.	2	0	3	0	8	0	18	4	15	8

Chlamydia

9 Have you heard of the Sexually Transmitted Infection called Chlamydia?
Yes 46 12 No 0 0

10 Who is most likely to get Chlamydia? *(Please tick one only)*
Women in their 20's/30's 26 4 People under 30 7 1 People in their 30's/40's 0 0 Don't know 13 7

11 If Chlamydia isn't treated can it cause infertility in women? (i.e. not able to become pregnant)
Yes 36 6 No 2 0 Don't know 8 6

12 Which of the following are symptoms of Chlamydia? *(Please tick one only)*

A spreading itchy rash over most of the body	3 0	Pus-filled lumps around the vagina or penis	4 0
Paralysis in a limb	1 0	All of the symptoms mentioned	3 1
None of the symptoms mentioned	12 4	Don't know	23 7

13 How is Chlamydia most commonly diagnosed? *(Please tick one only)*
Pelvic examination 1 2 Blood test 3 2 Urine sample 9 1 A swab 27 3 Don't know 6 4

14 Once Chlamydia has been treated, can you get it again?
Yes 38 10 No 0 0 Don't know 8 2

15 What is the best method of contraception/protection to use to protect yourself from Chlamydia?
Condoms 38 8 Pill 1 0 Don't Know 7 4

Getting Pregnant

16 Can you get pregnant the first time you have sex?
Yes 46 12 No 0 0 Don't know 0 0

17 Can you get pregnant if you have sex standing up?
Yes 46 11 No 0 0 Don't know 0 1

18 Does sperm come out of a man's penis before he ejaculates?
Yes 36 6 No 6 1 Don't know 4 5

19 Can you get pregnant if you have sex during your period?
Yes 37 9 No 2 0 Don't know 7 3

20 Can you get pregnant if the man withdraws before he ejaculates?
Yes 32 9 No 8 1 Don't know 6 2

21 If you have sex you might be pregnant, is there anything you can do to prevent pregnancy?
Yes 41 12 No 3 0 Don't know 2 0

22 Have you heard of emergency contraception, sometimes called the morning after pill?
Yes 46 12 No 0 0 Don't know 0 0

23 How long after unprotected sex / contraception failure are you able to take emergency contraception (pill) to prevent a pregnancy? *(Please tick one only)*
12 hours 3 0 24 hours 6 4 48 hours 5 0 72 hours 31 7 Don't know 1 1

Contraception Choices

24 I'd now like your **opinions** about different types of contraception/protection

		Very effective		Somewhat effective		Not too effective		Not effective		Don't know	
a	How effective are **oral contraceptive pills** at preventing pregnancy?	19	0	18	8	2	1	3	0	4	3
b	How effective are **oral contraceptive pills** at preventing STI's?	0	1	2	0	4	0	33	7	7	4
c	How effective are **condoms** at preventing pregnancy?	15	1	28	10	1	0	0	0	2	1
d	How effective are **condoms** at preventing STI's?	25	4	15	7	3	0	1	0	2	1

25 Tell me how you **feel** about these statements; there are no right or wrong answers.

		0		Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree	
a	It would not be that big a deal to have sex without a condom once in a while	1	0	2	0	6	1	5	0	18	3	15	8
b	You only need to use a condom if you have a lot of sexual partners.	1	0	1	0	5	1	6	0	17	6	17	5
c	Buying condoms is embarrassing	1	0	2	0	3	0	8	0	13	4	15	8
d	Sex without a condom isn't worth the risk	2	0	2	0	3	0	8	0	13	4	15	8

26 Below are a list of **feelings** you might have if someone you were having sexual intercourse with suggested using a condom, how strongly would you agree or disagree with each statement?

		0		Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree	
a	Relieved	[illegible]	0	13	5	26	4	6	2	0	1	0	0
b	Like the person respected me	1	0	20	4	24	8	1	0	0	0	0	0
c	Insulted	[illegible]	0	0	0	3	0	6	1	17	4	18	7
d	Suspicious or worried about the person's past sexual history	1	0	2	0	11	3	10	3	13	3	9	3
e	Like the person was suspicious/ worried about my past history	[illegible]	0	1	0	5	0	14	5	14	4	11	3

27 Tell me how you **feel** about the following statements regarding relationships and becoming sexually active.

a Once you have had sex it would be harder to say no the next time

0 1 0 Strongly agree 1 0 Agree 7 0 Neither 8 4 Disagree 24 5 Strongly disagree 5 3

b If you have been seeing someone for a while it is expected that you will have sex

0 1 0 Strongly agree 2 0 Agree 23 0 Neither 11 4 Disagree 7 5 Strongly disagree 2 3

c There is pressure to have sex by a certain age

0 1 0 Strongly agree 3 1 Agree 17 4 Neither 6 4 Disagree 15 2 Strongly disagree 4 1

d Oral sex is not as big a deal as sexual intercourse

0 1 0 Strongly agree 2 0 Agree 9 2 Neither 21 4 Disagree 11 3 Strongly disagree 2 3

e Waiting to have sex is a nice idea but nobody really does

0 1 0 Strongly agree 1 1 Agree 12 2 Neither 17 4 Disagree 12 4 Strongly disagree 3 1

Sexual Experience(s)

28 Please indicate if you have been involved in the following types of sexual activities.

	Yes		No		Not willing to answer	
Touching some one else's genitals	41	7	1	4	5	1
Sexual Intercourse (Penis into vagina)	46	0	0	10	0	2
Oral Sex	33	3	5	7	8	2
Anal Sex	4	0	36	11	6	1

29 Please select the option below which best describes you. *(Sexually active is defined as having sexual intercourse i.e. penis into vagina)*

Heterosexual – not sexually active	0 12	Heterosexual – sexually active	44 0
Lesbian – not sexually active	0 0	Lesbian – sexually active	1 0
Bisexual – not sexually active	0 0	Bisexual - sexually active	1 0

Questions 30 – 56: only completed by sexually active young women, n=46 (100%)

NB: This includes one sexually active lesbian and one sexually active bisexual young woman. Both women reported having had a male partner(s) in the past.

30 What age were you when you **first** had sexual intercourse?

Under 16 23 (50%) **16** 17 (36%) **17** 3 (7%) **18** 3 (7%) **19** 0 (0%)

31 How long were you seeing your **first** partner before you had intercourse?

0 1 (2%) **A day** 9 (19%) **A week** 2 (4%) **2 weeks** 2 (4%) **3 weeks** 2 (4%)
1 month 7 (15%) **2 months** 3 (6%) **3 months** 3 (6%) **Over 3 mthsr** 17 (40%)

32 What contraception/method did you use the **first time** you had sexual intercourse?

Withdrawal / pulling out 8 (17%) **Condom** 21 (47%) **Contraceptive Pill** 4 (8%) **Injectables/Implants** 0 (0%)
Condom & Oral Contraceptive Pill 11 (24%) **Condoms & Injectables/Implants** 1(2%) **0** 1 (2%)

33 If you didn't use a condom the **first time** you had sexual intercourse, what was your reason? (Please tick as many reasons as apply) *NO %- multiple response per person*

Not aware of a condom	8	Sex suddenly happened	7	Condom reduces pleasure	8
Condom not available	3	Felt shy to ask	0	Partner insisted not to use	1
Didn't know how to use one	1	Cost	0	Would interrupt sex	0
Other contraception used	0	Other _____	1	0 4	N/A 33

34 How many partners have you had in the past 12 months?

0 1 (2%) **None** 4 (8%) **1** 15 (34%) **2** 12 (27%) **3** 4 (8%) **4** 2(4%) **5 or more** 8 (17%)

35 Thinking about your **current sexual or most recent sexual** relationship, did you talk to your partner about:

		0	Yes	No	Don't know
a	SexuallyrTransmittedrInfections	1(2%)	21r(46%)	24r(52%)	0 (0%)
b	Contraception to prevent pregnancy	1(2%)	29 (63%)	16 (35%)	0 (0%)
c	Condoms	1(2%)	31 (67%)	14 (31%)	0 (0%)

36 Have you ever had unprotected sex (not used a condom) because you were drinking?

Yes 20 (44%) **No** 23 (50%) **Don't know** 2 (4%) **0** 1 (2%)

37 Have you ever worried about STI's or pregnancy because of something you did sexually while drinking?

Yes 19r(41%) **No** 26 (57%) **Don't know** 0 (0%) **0** 1 (2%)

38 The **first time** you had sexual intercourse had you been drinking?

Yes 8 (18%) **No** 36 (78%) **Don't know** 1 (2%) **0** 1 (2%)

39 The **most recent time** you had sexual intercourse had you been drinking?

Yes 9 (20%) **No** 37 (80%) **Don't know** 0 (0%) **0** 0 (0%)

40 In **general**, when you have sexual intercourse how often do you use contraception and/or protection?

All of the time 27 (59%) **Most of the time** 12 (26%) **Some of the time** 5 (11%) **Never** 2(4%)

41 Below is a list of types of contraception/methods or protection. For each one, please tell me if this is a method you have ever use?

		Yes	No
a	Withdrawal / Pulling out	15 (23%)	31 (67%)
b	Condoms on their own	38 (83%)	8 (17%)
c	Oral contraceptive pills on their own	29 (63%)	17 (37%)
d	Injectables or Implants on their own	4 (8%)	42 (92%)
e	Condoms & oral contraceptive pills together	27 (59%)	19 (41%)
f	Condoms & injectables/implants together	4 (8%)	42 (92%)

42 Have you **ever had** sexual intercourse without a condom?

Yes 34 (74%) **No** 12 (26%) **Don't know** 0 (0%)

43 If you have **ever had** sex without a condom, what was your reason? *(Please tick as many reasons that apply) NO %- multiple response per person*

Didn't know what a condom was	0	Sex suddenly happened	5	Condom reduces pleasure	3
Condom not available	4	Felt shy to ask	0	Partner insisted not to use	1
Didn't know how to use one	1	Cost	2	Would interrupt sex	3
Other contraception used	17	Other _____	3	0 6	N/A 12

44 The **last time** you had sexual intercourse did you use a condom?

Yes 17 (37%) **No** 28 (61%) **Don't know** 0 (0%) **0** 1(2%)

45 If you didn't use a condom the **last time** you had sex, what was your reason? *(Please tick as many reasons that apply)* *NO %- multiple response per person*

Not aware of a condom	0	Sex suddenly happened	6	Condom reduces pleasure	4
Condom not available	2	Felt shy to ask	0	Partner insisted not to use	0
Didn't know how to use one	0	Cost	0	Would interrupt sex	1
Other contraception used	15	Other _____	11	**0** 3	**N/A** 17

46 When choosing a method of contraception and/or protection how important are each of the statements, listed below, to you?

		Important	Not important	Don't know
a	How well it prevents pregnancy	39 (85%)	2(4%)	5 (11%)
b	How well it protects against STI's	36 (78%)	3 (7%)	7 (15%)
c	How much it costs	4 (8%)	36 (78%)	6 (14%)
d	What your partner wants to use	14 (30%)	23 (50%)	9 (20%)
e	That you don't have to discuss it with your partner	11 (24%)	24(52%)	11 (24%)
f	Availability at the time	23 (50%)	14 (30%)	9 (20%)

47 Have you ever been tested for a Sexually Transmitted Infection?

Yes 11 (24%) **No** 29 (63%) **Don't know** 0 (0%) **0** 6 (13%)

48 If you answered yes to question 47, did you have a Sexually Transmitted Infection

Yes 0 **No** 11 (24%) **Don't know** 0 **0** 6 (13%) **N/A** 29 (63%)

49 Have you ever used emergency contraception / the morning after pill?

Yes 15 (33%) **No** 24 (52%) **Don't know** 0 **0** 7 (15%)

50 Have you ever had a pregnancy test?

Yes 22 (48%) **No** 18 (39%) **Don't know** 0 **0** 6 (13%)

51 If you answered yes to question 50, were you pregnant?

Yes 2 (4%) **No** 20 (43%) **Don't know** 0 **0** 6 (14%) **N/A** 16 (39%)

52 Have you ever used a sexual health service e.g. Time2Talk, GP, Family Planning clinic?

Yes, before sex for the first time 9 (20%) **Yes, after sex for the first time** 18 (39%) **No** 9 (4**a**%)

53 What type of sexual health service did you use? *(Please tick as many as apply)* *NO %- multiple responses*

School based health service	7	Specialist service for young people	11	Family Planning Service	2
Doctor	10	Other ____ 0	**0** 0	**N/A** 19	

54 If you visited a sexual health service before you first had sexual intercourse, please state the reason / reasons why. *(Please tick as many as apply)* *NO %- multiple response per person*

To be prepared	8	Out of curiosity	2	You planned to have sex soon	10
To obtain information/advice	3	Other_____	10	**N/A** 37	

55 If you didn't visit before having sexual intercourse for the first time, please state the reasons reasons why. *(Please tick as many as apply)* *NO %- multiple response per person*

You didn't plan or expect to have sex	8	You got condoms from another source	4
You were worried about confidentiality	2	You didn't think about it	4
You were worried about your age	2	You didn't know of any services	0
Embarrassment	3	It would have been difficult to get there	1
Other (Please Specify)_____	8	**N/A** 37	

56 If you visited a sexual health service after you first had sexual intercourse, please state your reason / reasons for visiting *(Please tick as many as apply)* *NO %- multiple response per person*

To be prepared for the next time	2	To be prepared for sex with a new partner	0
To get condoms	9	To discuss and switch method of contraception	6
You had unprotected sex	6	Worried about sexually transmitted infections	2
Worried about pregnancy	7	Contraceptive failure	1
Pregnancy test	6	Emergency contraception	3
Other (Please specify) _____	3	**N/A**	23

PERSONAL INFORMATION *n*=58

57 What age are you?

16 19 (32%) **7 (15%)** **17** 12 (20%) **5 (8%)** **18** 12 (20%) **0 (0%)** **19** 3 (5%) **0 (0%)**

58 How would you describe your ethnic origin?

Asian or Asian British 0 0	Black or Black British 0 0	Mixed 0 0
White 46 (79%) 12 (21%)	European 0 0	Other Ethnic Group 0 0